SURGICAL NEWS

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Vol:10 No:10 November-December 2009

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THE COLLEGE OF SURGEONS OF AUSTRALIA AND NEW ZEALAND

PROFESSIONAL DEVELOPMENT
WORKSHOPS 2010

The College is offering exciting new activities for you to learn from and reflect on. Fellows at all stages of their career need to embrace professional development to ensure that FRACS always stands for excellence in surgical care.

NEW AMA Level 4/5: Difficult cases

11 February, Melbourne

20 August, Sydney

09 November, Brisbane

This new workshop provides surgeons involved in impairment assessments with a forum to discuss their difficult cases; the problems encountered and resolution steps applied. Fellows still need to attend accredited courses in the use of Australian Medical Association (AMA) Guidelines.

Practice Made Perfect: Successful Principles for Practice Management

3 March, Sydney

23 June, Adelaide

8 September, Melbourne

This all day workshop focuses on the unique challenges of running a surgical practice and the six principles of management; purpose, planning, promotion/ marketing, people, performance and problem solving. Practice staff and Fellows are encouraged to attend.

NEW Selection Interviewer Training

See website for dates

Fellows involved in the Surgical Education and Training (SET) selection interviews are invited to participate in this new course focusing on the key interview steps described by F.O.R.C.E.; Familiarise, Observe, Record, Classify and Evaluate. Selection legal and ethical issues are also discussed.

NEW Sustaining Your Business

26-28 March, Sydney

Effective business and financial planning is more important than ever for both private and public practices. This 2½ day workshop provides the foundation for developing business plans to sustain business growth and performance. It explores financial management from the preparation and analysis of budgets to the development of estimates and capital investment proposals.

Surgical Teachers Course

25-27 March, Melbourne

12-14 August, Newcastle

21-23 October, Adelaide

This course consists of 2½ days of challenging and interactive activities to enhance your educational skills. Experienced faculty members employ a range of teaching techniques to deliver the curriculum which includes adult learning, teaching technical skills, feedback and assessment plus change and leadership.

2010 PROVISIONAL DATES:
FEBRUARY - MAY

NSW

13 February	Supervisors and Trainers (SAT SET), Sydney
3 March	Practice Made Perfect, Sydney
26-28 March	Sustaining Your Business, Sydney

NT

26 March	Polishing Presentation Skills, Darwin

NZ

24 May	Supervisors and Trainers (SAT SET), Wellington

VIC

11 February	AMA Level 4/5: Difficult Cases, Melbourne
13 March	Communication Skills for Cancer Clinicians, Melbourne
25-27 March	Surgical Teachers Course, Melbourne
20 April	Supervisors and Trainers (SAT SET), Melbourne
27 May	Risk Management: Drafting a Consent, Melbourne

WA

23 February	Supervisors and Trainers (SAT SET), Perth (Urology)
30 April-2 May	Younger Fellows Forum, Perth (pre Annual Scientific Congress ASC)
3 May	Understand Your Patients Better: Become Culturally Competent, Perth (pre ASC)
3 May	Polishing Presentation Skills, Perth (pre ASC)
3 May	Supervisors and Trainers (SAT SET), Perth (pre ASC)

Further Information

Please contact the Professional Development Department on +61 3 9249 1106, by email PDactivities@surgeons.org or visit the website at www.surgeons.org - select Fellows then click on Professional Development.

The crisis in acute care surgery

Problems abound at all levels, but potential solutions may lie with surgeons themselves

Ian Gough
College President

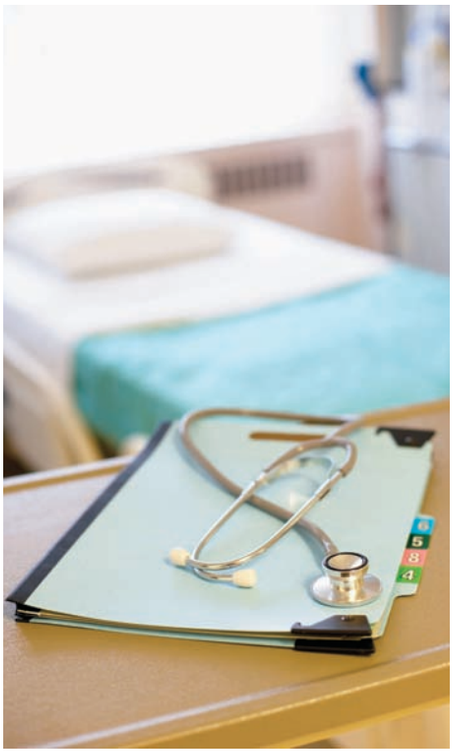
There is a crisis in acute surgical care in Australia and New Zealand. This is seen around the world but we need to find solutions that fit our own situations.

The media highlight the evidence on a daily basis: "ramping" of ambulances (ambulances and their crews waiting to decant their patients into Accident and Emergency (A&E) departments), congested A&E departments with patients on trolleys in corridors, competition for beds in the hospital and the queue for the operating theatres.

The problems are multi-factorial and require imaginative solutions. Patients with acute surgical needs should have access to appropriate facilities staffed by appropriately skilled surgeons. It is not only trauma patients but also those with a wide range of acute illness and the latter group actually constitute the majority of the demand.

In Western Australia the "four hour rule" is being introduced. This means patients should spend no more than four hours in A&E before being "disposed of". That's the management terminology that is used and it means that, almost at all cost and whether or not it makes clinical sense, the patient has to be out of A&E. This is ideally into an inpatient bed but in the United Kingdom, where this idea originated, it has led to ways of subverting the concept including transfer into a short stay ward nearby or even just a partition away. Worse still it may mean inappropriate discharge or transfer into an inpatient bed where the staff have less experience and availability than the A+E staff. This is an example of a management approach that has multiple flow on consequences, some favourable and others less so.

Once in a hospital bed there are problems of access to the operating theatre and the conflicting needs of other patients, especially booked elective patients. This results in delayed patient treatment and avoidable adverse outcomes. It is also very frustrating for surgeons and surgical staff and often requires working late into the night. This is one of the reasons the College has continued to advocate for separation of emergency (unplanned) hospital facilities and elective (planned) hospital facilities for surgical patients.



"Surgeons have the power to improve aspects of the system themselves by engaging and negotiating with colleagues and administration."

Traditional systems of on call rosters and principles of personal continuing care responsibilities may require the ongoing care and return to the operating theatre for several days after the period of duty when the patient was accepted. This also is very disruptive to other planned work.

A new paradigm is needed and progress is being made. Surgeons have the power to improve aspects of the system themselves by engaging and negotiating with colleagues and administration.

Many hospitals have now commenced an acute surgical unit type of rostering system. Details vary according to workload and numbers of available surgeons. The fundamental change is that the surgical team is on call for all emergencies for a defined period and does not undertake other routine clinical work in that time. They take on the unresolved problems of the previous team and hand over their unresolved problems to the next team. A team has discretion regarding the patients they hand over and those whose continuing care responsibilities they retain. The team is consultant led and that surgeon has real influence in determining priorities of operating theatre usage. Ideally there should be a dedicated emergency operating theatre with full staffing. Patients are treated in a timely and appropriate manner, usually in reasonable working hours. The "hangover" effect of continuing responsibility is resolved and safe working hours are more easily managed. The principles of "safe handover", of course, are critically important.

There are ongoing issues relating to recognition and reward of the surgical team for their acute surgical care work and these require negotiation with employers. Some other matters that must be addressed are more within our own sphere of influence. These include the relentless trend towards sub-specialisation and the related de-skilling and reluctance to participate in emergency rosters that I have written about elsewhere[1].

While our Early Management of Severe Trauma and Definitive Surgical Trauma Care courses are helpful, we need continuing professional development programs that specifically focus on the scope of practice of acute care surgery in each of our specialties. This is particularly important in general surgery and orthopaedic surgery. For example, surgeons have a need for regular updating and maintenance of skills in management of the range of problems that are within the scope of acute care surgery even though they may be wider than their day to day scope of practice in a subspecialty. The surgical workforce in Australia and New Zealand and the legitimate expectations of the community for access to competent surgical care means that all surgeons have to make a contribution to acute surgical care.

On 19 November the College is hosting a meeting to discuss and improve emergency surgery systems and there will be a report of the outcomes next year. Until then I wish to thank all Fellows and Trainees for their commitment and service to our patients and to the College. Please have a safe, happy and refreshing Christmas holiday season.

Reference 1: Gough I R. Subspecialisation of surgery and the continuing challenge of providing emergency surgery services. *Med. J Aust*. 2008, 189:358-359.

WHY NOT RUN NEXT YEAR?

There's never been a more **exciting** and interesting time to represent your colleagues and **College**.

2010 will be a big year for the College. A **new Constitution** will be put to a vote of Fellows, new arrangements for the registration of medical practitioners and the **accreditation** of training courses will come into effect in Australia, and the new **Surgical Safety Checklist** will be rolled out across operating theatres in Australia and New Zealand.

If these issues, and more broadly the **future of surgery**, surgical training and surgeons, are of interest to you, why not consider **running for Council?**

Look out for your nomination form, which will be mailed to you in early December.

For more information please contact the Vice President, Ian Dickinson college.vp@surgeons.org or Director of Relationships & Advocacy, James McAdam, james.mcadam@surgeons.org

Thanks for telling us

Your thoughts do matter… here is how

Ian Dickinson
Vice President

As you would be aware, the College undertook the 2009 Census of the Surgical Workforce between May and August. The first Census conducted since 2005, its purpose is to determine the scope of work being done by Fellows of the College, track any changes in the mix of public and private working hours, and identify patterns across the active and retiring membership. Of particular interest are the changing circumstances of Fellows working in regional, rural and remote locations.

This information enables us to gain a more accurate picture of the present and future requirements of surgeons in Australia and New Zealand. Created after an extensive consultation process involving office bearers, the Divisional Group of Rural Surgery, senior surgical Fellows, the Board of Regional Chairs, Chairs of Specialties, pilot groups, the Chief Executive Officer and Directors, the survey was sent to active Fellows and those who had retired in the past 12 months. Fellows are classified as "active" or "retired" on the College database in accordance with the information you have provided to the College. The definition of a retired Fellow is one who no longer does any work derived from skills developed as a surgeon and who has lodged a signed form to this effect with the College's Fellowship and Standards Department.

An excellent response rate of just over 80 per cent was achieved, and I sincerely thank Fellows for taking the time to participate in this important project. As a result of your involvement, the College has a robust body of information concerning the work practices of surgeons in Australia and New Zealand. Crucially, we also have a clearer awareness of current gaps in the surgical workforce and likely areas of future need.

"An excellent response rate of just over 80 per cent was achieved, and I sincerely thank Fellows for taking the time to participate in this important project."

More than 57 per cent of Fellows chose to complete the online version of the Census as opposed to the hard copy. The results of the Census are being published in *Surgical News* as they are analysed, to ensure we keep Fellows well informed. These findings will serve as the basis of the College's ongoing efforts to inform and influence decision makers in the ten governments with which we have dealings and in Health Departments across Australia and New Zealand. Only when armed with the most comprehensive and up to date information can we hope to support the development of a properly resourced and sustainable surgical workforce.

Working Hours

The Census of the Surgical Workforce in 2009 found that, on average, Fellows worked 59.5 hours per week over a four week period (Table 1.1). The findings demonstrate yet again the commitment of surgeons to public health, with every three hours worked in the private sector matched by two hours in the public sector.

It may be true that as work in the public sector has become increasingly challenging, with fewer beds available for elective surgery and competing demands for key infrastructure causing cancellation of operations, surgeons now perform in excess of 60 per cent of elective surgery in the private sector. However the "average" surgeon still maintains a substantial presence in the public sector. Much of this involves unremunerated or under remunerated activities. →

Correspondence to Surgical News should be sent to:
surgical.news@surgeons.org
Letters to the editor should be sent to:
letters.editor@surgeons.org
or The Editor, Surgical News,
Royal Australasian College of Surgeons,
College of Surgeons Gardens
250-290 Spring Street, East Melbourne Victoria 3002.
T:+61 3 9249 1200; F: +61 3 9249 1219;
W: www.surgeons.org

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There is also an obvious need to expand training opportunities in both the public and private sectors. Currently, on average, surgeons spend 13 per cent and four per cent of their time teaching in the public and private sectors respectively.

The issue of support has been highlighted in a number of studies across Australia, notably in the recent Special Commission of Inquiry into Acute Care Services in New South Wales (NSW) Public Hospitals. Commissioner Garling was particularly concerned about the support provided to clinicians as they provide supervision and oversight of Trainees as well as direct clinical care. There is no doubt that dedicated and protected time for supervisors will improve the standards of our training programs and in turn lead to better quality patient care. The College will work to ensure this issue remains a priority as consideration is given to hospital and healthcare reform packages.

Table 1.1 2009 Average hours worked per week over a four week period

Practice	Mean	Std. Dev	95% CI	
Public		2009		
Consulting	6.1	8.1	5.9	6.4
Operating	9.0	10.1	8.6	9.3
Ward Care	3.8	5.9	3.6	4.0
Administration	3.1	5.3	2.9	3.2
Teaching	3.2	3.9	3.0	3.3
Total	25.1	2.4	4.8	5.2
Private				
Consulting	15.0	12.8	14.6	15.4
Operating	11.2	11.1	10.9	11.6
Ward Care	3.6	4.6	3.4	3.7
Administration	3.5	4.3	3.3	3.6
Teaching	1.2	2.8	1.1	1.3
Total	34.4	4.5	6.6	7.1

As we wind down toward the Christmas and New Year period I would like to take this opportunity to wish you all a safe and happy festive season. There are a number of issues confronting our College in 2010 including the issues around national registration, the National Health and Hospitals Reform Commission proposals and our advocacy for better emergency surgery care. The introduction of the Surgical Safety Checklist in our two nations' hospitals will be a challenge for leadership and a successful referendum for the new College constitution will lead to more sound governance of the College.
I look forward to working with you in 2010.

2nd International Conference on Surgical Education & Training

13-14 May 2010

Royal College of Surgeons in Ireland, Dublin

Surgical Training in an Era of Reduced Working Hours

CALL FOR ABSTRACTS

Closing date for receipt of papers: Friday 18 December 2009
Abstracts must not exceed one page, Please use single spacing throughout.
Each abstract must contain the following:

- Full title of the abstract • Authors name
- Authors full contact details including hospital/institution and mobile phone number

All abstracts must be submitted electronically by logging to www.rcsi.ie/ICOSET

For further information please contact 2nd International Conference on Surgical Education & Training
C/o Communications Department
Royal College of Surgeons in Ireland
123 St Stephens Green, Dublin 2, Ireland
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E: icoset@rcsi.ie
www.rcsi.ie/ICOSET

Feminisation of the workforce

Workforce requirements must adapt to the rising number of women in surgical roles

I.M.A Newfellow

I was musing a few days ago that if it were not for that pesky Y chromosome this article might be being written by Ms. I.M.A Newfellow. Now I do admit that these musings were during the Financial Report to Council. Our Treasurer, Keith Mutimer, is such a nice chap that one can't help but like him but balance sheets, income and expenditure and budgets don't excite me all that much. I was pondering on what the "I.M.A" might stand for if I was female. I have already revealed that the "I" stands for Ian. If I were born in 2008 I could have been an Isabella (or one of its variants), an Imogen, an Isla or even an Indiana as these are the four most popular girls' names staring with "I" that are in the top 100 girls' names for 2008. Indiana Newfellow has a certain ring to it, don't you think? I note that unfortunately Ian is not in the top 100 boys' names – the only "I" name is Isaac.

As usual I have diverted from my real theme which is the place of women in surgery. I will ignore that curmudgeon who is protesting with a loud "None". What are the facts? Of our active Fellows seven per cent are female; of our Trainees 23 per cent are female and of our Surgical Education and Training (SET) 1 Trainees who started in 2008, 27 per cent are female. There appears to be an increasing feminisation of the surgical workforce.

One question that arises is "Does this increased feminisation affect the workforce requirements?" It certainly does in general practice where female general practitioners work about two thirds times the hours that males do. Is it the same in surgery? The short answer is that we do not know as yet but the data from the 2009 College workforce study should give us a hint to the answer. If it is "Yes" then our training programs must be able to respond rapidly with an increase in the output of trained surgeons.

Now if I were minus that Y chromosome and had two X's would I have gone to medical school? Would my parents have considered that I was "just a girl" and encouraged me to train to be an office worker rather than allowing me to enter university? If I was a bit more persistent would I have been considered medical school material? After getting a medical degree would I have had the gumption to try to enter the male bastion of surgery? Would I have had a male mentor who was willing to put aside prejudices and assist me in achieving my goal? Would hospital administrators have given me a fair go?

"So listen here all you Ians and Isaacs – make way for the Isabellas, Imogens, Islas and Indianas."

This all sounds a bit far fetched but ask any female surgeon about these biases and she will tell you that she has had such problems.

So listen here all you Ians and Isaacs – make way for the Isabellas, Imogens, Islas and Indianas, especially for my as yet unborn granddaughter Indiana Newfellow and be grateful that she is not an Indiana Jones.

Mortality audit

A waste of time, or an opportunity wasted? We must continue to show that we can regulate an accurate audit

Paul Dolan
Clinical Director, SAAPM

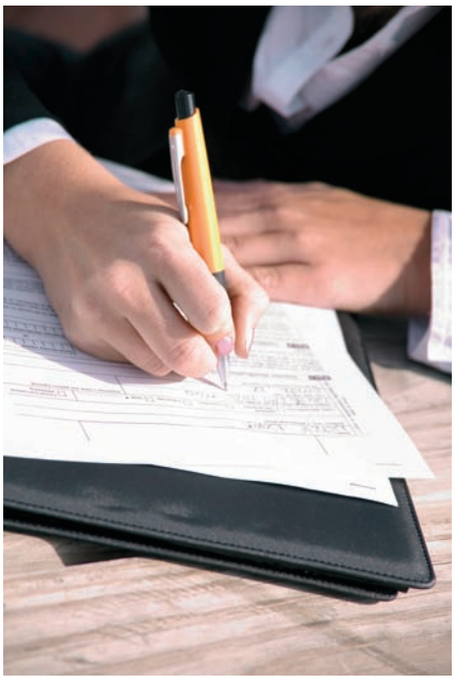
As the Clinical Director of the South Australian Audit of Perioperative mortality, I receive a range of feedback from surgeons about the mortality audit process. A recent corridor conversation with a colleague produced the observation that he was 'still filling out those mortality forms of yours, although it all seems a bit of a waste of time'.

In my role, one is expected to absorb these sorts of comments and promote the benefits of the audit. However, as a realist, I also have to acknowledge that this view is possibly shared by many others, hopefully to a lesser degree!

In general, surgeons' participation in the various state audits has been excellent, with over 95 per cent of South Australian surgeons, for example, indicating 'in principle' support for the project. If we look at the return rates for case forms, some specialties have achieved response rates in excess of 80 per cent, although regrettably there are some groups in which participation is much lower. There are also situations in which case forms are returned with rather less detail than one might expect, or are completed by the Trainee, often without much evidence of consultant input. This unfortunately often leads to delays in the process, as case notes or discharge summaries may need to be obtained to allow a fair and adequate case assessment.

So, why bother with statewide mortality audits?

Surgeons are generally very interested in studying the results of their work. Surgical units across Australia collect and publish their data and are keen to compare their results with their peers. When it comes to mortality, however, the situation is different. Most surgical units do not have large numbers of deaths, so we are less inclined to collect data about small numbers of cases, particularly in the context where the fatal outcome seemed inevitable. In the case of emergency admissions, particularly to major teaching hospitals, the death of a patient is usually due to the underlying disease process in about 90 per cent of cases, regardless of treatment. Hence the possible perception that this data collection is a 'waste of time.'



"Surgical units across Australia collect and publish their data and are keen to compare their results with their peers."

The Australian health care system is widely regarded as one of the best in the world, and as doctors we are justly proud of its reputation. However, our claims to excellence can only be upheld if we have data to support us. While individual hospitals have in-house mortality reviews, the results are never published and the data can never be collated to show a bigger picture.

Prior to the commencement of the statewide mortality audits, there was no coherent information to show the demographics of surgically-related deaths in Australia – the work simply had never been done. The health system had no overview to indicate how many patients died, or under what circumstances, or whether there were trends or recurring problems in the system which might need to be addressed.

The current audit process provides surgeons with the opportunity to have an anonymous, peer-reviewed, third-party assessment of their patients' treatment when a death has occurred. Through the Australian and New Zealand Audit of Surgical Mortality, the College governance process goes to great lengths to ensure procedural fairness for all contributing surgeons. There is no other specialist medical group in Australia which has access to an equivalent process.

With the various state audits contributing to a national database, information is accumulating for a large number of cases, and patterns of care are beginning to emerge. We are now able to support our assertion that the Australian surgical community has a high standard of practice, and we can show that when fatal outcomes do occur we have a mechanism in place to look for potential underlying causes.

Governments provide funding for the audits, and allow the College to control the process on the grounds that the best judges of surgical outcomes are surgeons themselves. We must continue to show that we can regulate a robust and accurate mortality audit, which means active participation by all surgeons. If we dismiss the audit as a waste of time, we run the risk of losing a unique opportunity to maintain the historically high standards of surgery in Australia. Surely our patients and their families would expect nothing less than this?

College Conferences and Events Management

Contact Lindy Moffat / lindy.moffat@surgeons.org / +61 3 9249 1224

AUSTRAUMA 2010

Trauma, Critical Care and Emergency Surgery Conference

Sydney Convention & Exhibition Centre, Darling Harbour, Sydney.
11 – 13 February 2010

Conference Convener: **Dr Valerie Malka**

Conference Themes:

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- Mass Casualties
- Neurotrauma
- Paediatric Injuries
- Trauma Radiology
- Animal Injuries
- Orthopaedic Emergencies
- Emergency General Surgery
- Damage Control
- Critical Care Nightmares

Contact: **Emma Thompson**
Conferences and Events Department
Royal Australasian College of Surgeons

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Informing patients properly

Good communication prepares patients and reduces the risk of liability to surgeons

Michael Gorton
Principal Russell Kennedy Solicitors

A recent report in the Medical Journal of Australia *(Vol. 191/5 – 7 September 2009 "Adequacy of Consent Documentation in a Specialty Surgical Unit")* raises the question of how well doctors are informing their patients of the risks and options for surgery.

In a retrospective review of consent forms used in a particular hospital unit, with over 1200 consent documents evaluated, substantial deficiencies were identified:

- inadequate description of the procedure to which the patient was consenting;
- frequent use of jargon, acronyms and technical language;
- inadequate description of the purpose or reason for the procedure;
- substantial failure to disclose risks;
- substantial failure to disclose alternative treatments.

Of course there is a substantial difference between the information conveyed by the doctor in discussions with the patient, compared with the actual information conveyed on the form itself. Hopefully, doctors are providing all of the necessary information for informed consent, through personal discussions with the patient on each occasion, before asking the patient to sign a "consent form".

Proper communication with the patient about the risks and options for treatment is a valuable risk management tool for doctors. By explaining the risks of any surgical procedure, the doctor will prevent unrealistic expectations, where the patient may be expecting a "perfect" result. Similarly, where adverse events occur, which may be a natural outcome of the procedure, the patient will be prepared, and will more readily accept the explanation of the surgeon in relation to the outcome.

It should also be noted that recent data of insurance claims notified between July 2003 and June 2007 (Medical Indemnity Report, Medical Indemnity Industry Association of Australia, 31 July 2008) discloses 193 claims relating to consent, out of a total of approximately 6,000 claims – or approximately three per cent of the proportion of claims.

Doctors will be aware of their specific legal obligation to warn all patients of the material risks inherent in any proposed procedure or treatment. In essence, risks are material if they are likely to change the mind of the patient as to whether or not they proceed with the treatment. They may be significant risks, because a reasonable person would want that information and may change their mind, or the risks may be particularly significant to the particular patient, who may change his or her mind.

Informed consent is about good communication. If done well it substantially reduces the risk of liability of the doctor, whether or not there may in fact be negligence in treatment.

Some practical aspects of informed consent are:

Make time for the discussion

It is difficult, given the limited time available to surgeons, particularly with day procedures, to have the detailed discussion with the patient necessary to deal with informed consent. Time for this discussion needs to be planned.

Use plain language

Acronyms, medical terms and even Latin are unacceptable. The information must be conveyed to the patient in a form and in a manner which they can understand. (In the surveyed documents in the Medical Journal of Australia Article above, 81 per cent of consent forms used technical descriptions of the intended procedure, alone or combined with acronyms).

For people from a non-English speaking background, appropriate translation would be required.

Describe risks by their effects on patients

Some doctors describe risks in terms of medical complications or medical conditions which may arise from a procedure. This does not adequately inform the patient of the effect it is likely to have on them. Rather than medical jargon, risks can be combined into general statements on what lasting effect it will have on the patient in their daily life – numbness, sickness, headache, loss of mobility, etc. Again, plain language would be most effective.

Use appropriate information sheets

Many doctors now use information sheets or general brochures, which can also aid communication. They are not a replacement for informed consent, and the personal discussion with the patient, but can be a significant aid to understanding for the patient.

Prepare a checklist

A checklist of the most significant risks and items for discussion with the patient can be a useful aid to remind the doctor of the items to be discussed, as well as creating a document of the discussion – a record of the discussion which may be necessary to defend any later claims about failure to obtain informed consent.

Informed consent is part of good communication with a patient. Doctors should also keep detailed notes and records, not just of treatment but of the advice and information conveyed to the patient during the informed consent process.

College Guidelines appropriately highlight consent requirements, and reinforce the message that, "consent is a process, not just a document".

For information about the College's Informed Consent Workshop visit www.surgeons.org and select Fellows.

Chalice ... poison'd? Continued...

The future of surgery depends on our ability to develop and empower our leaders

Professor U.R. Kidding

"Some are born great, some achieve greatness, and some have greatness thrust upon 'em" (Act ii Scene V, *Twelfth Night, or What You Will*).

I was reflecting upon that as I was again reviewing the Unit Structure that I had introduced into the hospital. I had been doing a lot of "thrusting" recently.

It is interesting to me that surgeons, undoubtedly ambitious and always up for a challenge, are loath to volunteer themselves. Yet when approached to take on a task, they usually respond positively. I can't be too critical – my own situation verifies the truth of this. Is it possible that surgeons are secretly modest? No, secretly immodest more likely, and have learnt, over time, how to hide it so that it becomes second nature! But then again, maybe they are just busy people.

So I now have every surgeon in the hospital a member of a Unit and I have a Head of Unit for each Unit. I have a "structure" – but will it be effective? What makes a structure effective?

Just about all surgeons I speak to complain of being marginalised in our increasingly complex and unfortunately bureaucratic health care system. To my mind the breakdown of unit structure inside hospitals is one of the key signs of decay and irrelevancy. Units need to involve all surgeons – and they need leadership at a Unit level. Of course communication and engagement are essential also.

The perceptions of surgeons needs to move from threatened, negative and backbiting to constructive, co-ordinated and cohesive — able to offer solutions. They need to engender value, quality and to pass this on to trainees and students.

I have great faith in surgeons. They are innovative, progressive determined. They are problem solvers, prioritisers, implementers and completely disinterested in bureaucratic paperwork, delay and anything perceived to be irrelevant. I have managed to appoint "great" unit heads but now I have to empower them, both within their Units and to the management. I have resolved to do nothing with or within a Unit without involving the Head of Unit. We need to develop our leaders. The future of surgery does depend on it.

Those skills of communication, stakeholder management, advocacy and even running meetings reliably are things that we all need to understand and respect. Perhaps I can get the College to organise a few professional development courses about it.

My "structure' has done one thing already – it has empowered me in dealing with management. They know about my surgical structure – are they a little wary? I did enjoy the meeting with the hospital Chief Executive when all of us had got together and prioritised the capital purchases for the next year! Amazing how new equipment in clinical areas helps boost morale. Even better, the Heads of Units voted for the most appropriate, not necessarily those that benefited their unit particularly.

Twelfth Night, or What You Will is regarded as one of Shakespeare's greatest comedies. It was written and first performed around 1600-01.

"The perceptions of surgeons needs to move from threatened, negative and backbiting to constructive, co-ordinated and cohesive — able to offer solutions."

With a bit of a dig against the aristocrats of the day, it does highlight that world where the wealthy would do little work and possessed the liberty to do as they pleased!! I think I am living in the wrong era. Certainly being the Director of Surgical Services will never have me in the land of the "independently wealthy".

Twelfth Night contains another quote - "out of the jaws of death" (Act iii. Scene 4). As I head off to a meeting of the Hospital Board where waiting list strategies are to be discussed — something about keeping the Minister happy — I am aware of a dark cloud approaching. It is building in strength — its name is audit. Enough of Shakespeare's comedy, for this I need a political thriller, perhaps Julius Caesar...

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Convocation

The Convocation marks the commencement of each Annual Scientific Congress (ASC); for recent graduates, it marks their formal induction into the College. Wearing the College academic robe to signify their new status, these young Fellows are formally introduced to the College President by the Chair of the Court of Examiners in front of College Council. Any Fellow who has received their diploma in the last five years is welcome to nominate for presentation to the President (see following page). The 2010 Convocation will be held in the Riverside Theatre at the Perth Convention Exhibition Centre at 4.30pm on Monday 3 May. The Convocation will be followed by the Welcome Reception on the adjacent terrace overlooking the Swan estuary.

Syme oration

The second feature of the Convocation is the George Adlington Syme oration. This is the College's most prestigious lecture and commemorates Sir George Adlington Syme, the College's first President. Of 20 minutes duration, a panoply of eminent surgeons, academics and political leaders including Lee Kwan Yew, Sir Zelman Cowan and Professor Paul Callaghan have delivered this oration. In Perth, the distinguished academic and environmental scientist, Professor Jorg Imberger AM PhD will deliver the Syme oration titled *'Death of the environment; social icons and personal connectivity: Denial, anger, bargaining, depression and acceptance'.*

All delegates who register for the ASC receive complimentary tickets to the Convocation and the Welcome Reception.

Abstract submission

A vital component of the various scientific programs is the opportunity it affords Fellows and Trainees to present research. The call for research abstracts has been published and the abstract submission site may be accessed at asc.surgeons.org Abstracts may be submitted for oral presentation or for poster format. Abstracts for all research presentations and posters accepted onto the programme will be published in the Supplement to the May 2010 *ANZ Journal of Surgery*.

Plastic and Reconstructive Surgery

The convener of the Plastic and Reconstructive Surgery program, Mark Lee tells us that there will be a full four-day program with synchronous Reconstructive and Aesthetic sessions that will appeal to all plastic surgeons, no matter what their practice profile. For the Trainees, there will be a research prize for the best research abstract in each of Reconstructive and Aesthetic surgery, presented by Covidien.

Mark has secured the attendance of four excellent international visitors to complement the plastic surgeon speakers from Australia and New Zealand.

Dr David Fisher (Toronto), has a major interest in cleft lip and palate surgery. The 'Fisher repair' is now a mainstay of many cleft units around the world. Anyone managing cleft patients or involved with overseas aid missions would be very interested in seeing David's talks. His wife, Dr Leila Kasrai, a renowned microtia reconstructive surgeon in Toronto will also speak on the program.

Dr Wayne Perron (Calgary) is a past president of the Canadian Society of Aesthetic Surgery and he will contribute heavily to our aesthetic sessions, particularly in breast augmentation and facial aesthetic surgery.

Professor Claes Lauritzen, Professor of Plastic Surgery in Gothenburg, Sweden, is the BK Rank Visiting Professor. He is a major innovator in craniofacial circles, particularly in the recent advance of using springs and distraction for cranioplasties. Professor Lauritzen also has a major interest in aesthetic surgery and will have the added bonus of contributing to our sessions on facial aesthetics and breast augmentation.

Dr Jerome Stevens from Rotterdam is a pioneer in large-volume fat transfer, a technique gaining widespread use in areas such as breast reconstruction, breast augmentation and other reconstructive and aesthetic surgery where previously only free tissue transfer achieved similar results. Dr Stevens will also contribute to sessions on aesthetics and surgical education, particularly web-based systems.

A bonus is the Head and Neck Visitor, Professor Subramania Iyer, who trained in both Plastic Surgery and Ear Nose and Throat surgery. We have developed a very good combined head and neck program that should appeal to all plastic surgeons involved in this area, particularly those involved in microsurgical reconstruction.

Excellent combined sessions are planned with the breast surgeons (radiotherapy and reconstruction), rural surgeons (hand surgery), oncologic surgeons (melanoma) and the paediatric surgeons on chest wall reconstruction.

There are three relevant Master classes: Tuesday (MC2) on breast oncoplastic techniques; Thursday (MC10) on cleft lip repair and Friday (MC15) where the invited faculty will discuss 'Procedures I no longer perform'.

Plastics dinner

Delegates should note that the Plastic and Reconstructive Surgery dinner is on the Wednesday night, not Thursday as listed in the Provisional Program.

Pain Medicine

The convener, David Holthouse tells us he is focussing on neuromodulation. Pain is the presenting symptom in 90 per cent of clinical presentations and implantable therapies offer relief to chronic pain sufferers and provide an alternative or an adjunct to medication. Implantable techniques are readily learnt and are very successful. His program draws on a wide range of experience from Europe, the United States and Australia.

Dr Tony Van Havenburgh is a neurosurgeon from Antwerp with extensive experience in the implantation of spinal and cortical electrodes. Dr James Hagen and Dr Dan Bennett are members of an experienced and innovative implant team from Denver, Colorado. They have extensive knowledge in implantation and programming of stimulators within a strong research base. Richard Bittar is a neurosurgeon from the Royal Melbourne Hospital involved in deep brain stimulation and has successfully applied this to pain management. In addition, local speakers will be presenting their experiences on different aspects of neuromodulation including its role in bowel, uro-gynaecological and movement disorders. The program will provide a comprehensive and engaging overview of the whole topic.

We look forward to welcoming you to Perfect Perth in May 3- 7.

Correction: The name of the Western Australian Minister of Health in the October *Surgical News* was incorrect, it should have read The Honourable Dr Kim Hames.

Convocating Fellows

Fellows of the College may convocate at the Convocation ceremony at 4.30pm on Monday 3 May 2010 at the Perth Convention Exhibition Centre. Convocating Fellows receive complimentary registration for the ASC. Details can be found by visiting the website asc.surgeons.org and clicking on 'I want to convocate'.

If you have received your Fellowship within the last five years, and have not previously convocated, you may do so in Perth.

To convocate, register for the ASC by completing the details on the registration form in the Provisional Program and return it to the College's Conferences and Events department. Tick the box to indicate that you wish to convocate. Further information will then be sent to you regarding the ceremony and gown hire.

2010 Scholarship and Grant Recipients

The Board of Surgical Research thanks all applicants and congratulates the following successful recipients

Peter Stanton
Chair, Board of Surgical Research

Research Scholarship and Fellowship Recipients

The College wishes to acknowledge and thank our benefactors and sponsors for their generosity in funding many of the following scholarships and grants.
Where indicated * scholarship recipients must procure 25 per cent of their scholarship from either their research department or by external award or donation.

John Mitchell Crouch Fellowship
Associate Professor Damien Bolton
Fellowship Value - $75,000

Associate Professor Damien Bolton is based at the Department of Surgery, University of Melbourne and is the Director of Urology, Austin Hospital, Victoria. He is also a Senior Fellow of the University of Melbourne Undergraduate Clinical School at the Austin and Northern Hospitals. Associate Professor Bolton is currently involved in research into renal cell carcinoma at the University of Melbourne and the Ludwig Institute for Cancer Research. His work primarily focuses on mechanisms of renal tumour regulation, particularly on the impact of tumour hypoxia, and the role of GRP as a mediator of tumour behaviour in renal and prostate cancers. The John Mitchell Crouch Fellowship will assist Associate Professor Bolton to continue his research into renal cell carcinoma, with the aim of understanding and managing the condition more effectively.

Surgeon Scientist Scholarship*
Dr Yi Chen
Specialty: Cardiothoracic
Scholarship Value - $70,000
Topic: Activin A and myocardial ischemia reperfusion injury
Supervisor: Professor Julian Smith

Eric Bishop Scholarship*
Dr Johnny Wong
Specialty: Neurosurgery
Scholarship Value - $60,000
Topic: Investigating fluid flow and pulsations in post-traumatic syringomyelia.
Supervisor: Professor Marcus Stoodley

Raelene Boyle Scholarship – Sponsored by Sporting Chance Cancer Foundation*
Dr Zoe Wainer
Specialty: Cardiothoracic
Scholarship Value - $60,000
Topic: Identification of tumour genetic predictors of metastasis in patients with resected lung cancer.
Supervisor: Mr Gavin Wright

Paul Mackay Bolton Scholarship for Cancer Research*
Dr Adam Frankel
Specialty: General
Scholarship Value - $60,000
Topic: Genome-wide analysis of oesophageal cancer: towards biomarkers of response and outcomes of therapy.
Supervisor: Dr Andrew Barbour

WG Norman Research Fellowship*
Dr Leong Ung Tiong
Specialty: General
Scholarship Value - $60,000
Topic: Bimodal Electric Tissue Ablation (BETA) - The safety and efficacy study.
Supervisor: Professor Guy Maddern

Foundation for Surgery Reg Worcester Research Fellowship*
Mr Charles Pilgrim
Specialty: General
Fellowship Value - $60,000
Topic: Predicting chemo-induced hepatic injury on clinical, genetic and imaging parameters.
Supervisor: Professor Robert Thomas

Foundation for Surgery John Loewenthal Research Fellowship*
Dr Russell Hodgson
Specialty: General
Scholarship Value - $60,000
Topic: Tolerance induction to porcine islets in preclinical transplant models.
Supervisor: Professor Mauro Sandrin

Foundation for Surgery Catherine Marie Enright Kelly Scholarship*
Dr Sidney Levy
Specialty: General
Scholarship Value - $60,000
Topic: The role of VEGF-D in lymphatic function.
Supervisor: Associate Professor Marc Achen

Foundation for Surgery New Zealand Research Fellowship*
Dr Deborah Wright
Specialty: General
Scholarship Value - $60,000
Topic: Prognostic modelling of colorectal cancer using multiple data sources.
Supervisor: Associate Professor Crispin Print

Foundation for Surgery ANZ Journal of Surgery Scholarship*
Dr Matthew Hong
Specialty: Urology
Scholarship Value - $60,000
Topic: Biomarkers in prostate cancer: utility in detection, response to treatment and prognostication.
Supervisor: Dr Christopher Hovens

Foundation for Surgery Research Scholarship*
Dr Lisa Doyle
Specialty: General
Scholarship Value - $60,000
Topic: The impact of weight loss on the metabolic syndrome.
Supervisor: Associate Professor Wendy Brown

Foundation for Surgery Research Scholarship*
Dr Kieran Rowe
Specialty: General
Scholarship Value - $60,000
Topic: Development of novel methods for adipose tissue engineering.
Supervisor: Dr Keren Abberton

Foundation for Surgery Research Scholarship*
Dr Mark Miu Fei Lam
Specialty: Neurosurgery
Scholarship Value - $60,000

Topic: Convection-enhanced delivery of neuroprotective agents to the striatum.
Supervisor: Associate Professor Christopher Lind

Foundation for Surgery Research Scholarship*
Dr Kapil Sethi
Specialty:Urology
Scholarship Value - $60,000
Topic: Ischemic preconditioning of the kidney by activation of hypoxia inducible factor 1a.
Supervisor: Associate Professor Graham Baldwin

Foundation for Surgery Research Scholarship*
Dr Jonathan Negus
Specialty: Orthopaedics
Scholarship Value - $60,000
Topic: A radical new method of rehabilitation post knee surgery using the Nintendo Wii.
Supervisor: Associate Professor Lynette March

Plastic and Reconstructive Surgical Research Award and Foundation for Surgery Research Scholarship*
Dr Raminder Dhillon
Specialty: Plastic and Reconstructive
Award Value - $25,000 and Scholarship Value - $60,000
Topic: The role of dysregulated vascular endothelial growth factors (VEGFs) in lymphatic malformations.
Supervisor: Mr Anthony Penington

CONROD-RACS Trauma Fellowship
Dr Michael Wagels
Specialty: Plastic and Reconstructive
Fellowship
Value - $50,000
Topic: Free muscle flap vascularity and neovascularisation - Implications for future surgery and trauma management.
Supervisor: Dr David Theile

Travel Scholarship, Fellowship and Grant Recipients

Margorie Hooper Scholarship
Dr Benjamin Teague
Specialty: General
Scholarship Value - $65,000

Stuart Morson Scholarship in Neurosurgery
Dr Timothy Siu
Specialty: Neurosurgery
Scholarship Value - $30,000

Murray and Unity Pheils Travel Fellowship
Mr Christopher Wakeman
Specialty: General
Fellowship Value -$10,000

Morgan Travelling Scholarship
Mr Falah El-Haddawi
Specialty: General
Scholarship Value - $10,000

Hugh Johnston Travel Grants
Dr Matthew Peters
Specialty: Plastic and Reconstructive
Grant Value - $10,000
Dr Jonathan Wheeler
Specialty: Plastic and Reconstructive
Grant Value - $10,000
Dr Niall Corcoran
Specialty: Urology
Grant Value - $10,000

Ramsay Fellowships for Provincial Surgeons – 2009
Mr Stephen Hayes
Fellowship Value - $2,000
Dr Tamaris Hoffman
Fellowship Value - $10,000

Other Scholarships

The following lists external awards that Fellows and Trainees of the College have been successful in attracting from other organisations.

The Garnett Passe & Rodney Williams Memorial Foundation
Dr Sam Boase
Gross value of award - $210,000 over three years
Specialty – Otolaryngology, Head and Neck Surgery
Project title - Investigating the role of fungus in chronic rhinosinusitis

The Garnett Passe & Rodney Williams Memorial Foundation
Dr Andrew Foreman
Gross value of award - $210,000 over three years
Specialty - Otolaryngology, Head and Neck Surgery
Project title - The role of biofilms in chronic rhinosinusitis

The Garnett Passe & Rodney Williams Memorial Foundation
Dr Rowan Valentine
Gross value of award - $210,000 over three years
Specialty - Otolaryngology, Head and Neck Surgery
Project title - Haemostatis and wound healing following endoscopic sinus surgery

Medtronic-NSA Research Scholarship
Dr Nicholas Hall
Gross value of award - $55,000
Specialty - Neurosurgery
Project title - The application of mesenchymal stem cells in the spine - effects on fusion, disc regeneration and modelling a biomimetic disc

NSA Research Scholarship
Dr Gemma Olsson
Gross value of award - $55,000
Specialty- Neurosurgery
Project title - Tumour initiating cells in glioblastoma multiforme

Synthes-NSA Research Scholarship
Dr Nova Thani
Gross value of award - $50,000
Specialty - Neurosurgery
Project title - Function of the zona incerta in humans and its role as deep brain stimulation target for Parkinson's disease and essential tremor

NSA Research Scholarship
Dr Mark Miu Fei Lam
Gross value of award - $5,000 (top up)
Specialty - Neurosurgery
Project title - Convection enhanced delivery of neuroprotective agents to the striatum

Synthes-NSA Research Grant
Dr Andrew Davidson
Gross value of award - $35,000
Specialty - Neurosurgery
Project title - The application of focused ultrasound and a vascular targeting strategy in an animal model of human brain AVM

Stryker-NSA Research Grant
Professor Neville Knuckey
Gross value of award - $35,000
Specialty - Neurosurgery
Project title - In vitro assessment of potential neuroprotective proteins

Medtronic-NSA Research Grant
Professor Michael Murphy
Gross value of award - $35,000
Specialty - Neurosurgery
Project title - Interleukin-6 and oncostatin M protein expression in human glioblastoma multiforme

Australasian Urological Foundation -Bruce Pearson Fellowship Grant
Associate Professor Damien Bolton
up to $75,000
Specialty: Urology
Prostate Cancer in BRCA2 Mutation Carriers

Australasian Urological Foundation Grant
Mr Paul Sved
up to $30,000
Specialty: Urology
Relationship between Arachidonic Acid and Protein Kinase B Signalling Pathways in Prostate Cancer.

Australasian Urological Foundation Grant
Dr Kapil Sethi
up to $30,000
Specialty: Urology
Ischaemic Preconditioning of the Kidney through HIF1a.

Australasian Urological Foundation Grant
Dr Benjamin Namdarian
Specialty: Urology
up to $30,000
Steroid synthesis in castrate resistant prostate cancer tissue.

Siren song of the sea

Vascular surgeon Mr David Huber has a love of sailing in his blood, his parents spent ten years sailing around Europe

A love of sailing is in the blood for vascular surgeon Mr David Huber. Having taken up the sport at age six when his family were located in Strathfield, NSW, he has raced both yachts and dinghies and now co-owns a Sydney 36 sailing boat which he sails in the waters off Sydney with two other doctors.

His parents, Felix Huber, a surgeon, and Rina Huber, an anthropologist, spent almost ten years sailing around the glorious waters of Europe, a journey Rina describes in a book published in 1997 entitled *Nine Summers: Our Mediterranean Odyssey*. As many surgeons can no doubt understand, it is the "uncontactability" while on the water that Mr Huber says is one of the chief attractions.

"There is a great sense of freedom when you're out in the boat, particularly when you're into short-handed sailing, that is, with only one or two other people out there with you. It's about self-reliance and solitude but even more I think it is one of those activities that beautifully combine both physical and intellectual endeavour," he explains.

Mr Huber is the Chief of Department of Vascular Surgery at the Illawarra Health Area Service and is the founder of the first endovascular suite in an operating theatre in a public hospital in Australia. Established at Wollongong Hospital, the suite remains the only one of its kind in the country.

For most of his surgical career, Mr Huber has attempted to get out on the water at least once a week yet for the past two years even that time has been unavailable to him as he focuses his energies on the design and manufacture of a pressure relieving device called the "Guardaheel" aimed at reducing the incidence of pressure ulcers developing in the ankles and feet of patients undergoing surgery.

"There is a great sense of freedom when you're out in the boat, particularly when you're into short-handed sailing, that is, with only one or two other people out there with you."

Mr Huber appeared on the ABC program "The New Inventors" to explain the design and purpose of the device in May this year.

Yet despite his focus on solving the problem of pressure ulcers, the siren song of the sea remains.

"I have really missed sailing in these past two years. While I have always been more into racing, my parents were more into cruising and now I am starting to dream of that too. I'd love to sail around Australia with my wife Anne Wolfers and then do some high altitude cruising, or cold-climate cruising as it's called, in Northern Europe or around the North Atlantic," he says.

"That is definitely the plan but as with all such grand plans it's not just about finding the time but finding the right time."

A transfusion increases your patient's risk of nosocomial infection

True or False

Join the debate at www.theTransfusionquestion.com.au

Blood Watch, a Program of the NSW Clinical Excellence Commission.

An academic surgeon

Dr Mittal has been investigating the link between intestinal ischaemia and mesenteric lymph in acute pancreatitis


Anubhav & Dipti Mittal in Santorini

Since 2007, New Zealand general surgery Trainee Anubhav Mittal has been awarded both the College Foundation for Surgery Research Scholarship and the College Foundation for Surgery New Zealand Research Fellowship to allow him to develop his understanding of the disease processes associated with acute pancreatitis.

Undertaking his research as part of a PhD, Dr Mittal has spent those years investigating the link between intestinal ischaemia and mesenteric lymph in acute pancreatitis in the hope that targeted therapies may be designed in the future to help reduce the high morbidity and mortality associated with the disease.

His findings have been published in the *World Journal of Surgery* and the *British Journal of Surgery* and he has won a swag of prizes and scholarships for his work including the Young Investigator Award by the Surgical Research Society of Australasia, the Sir Louis Barnett Prize, presented by the College, and the Best Presentation, PhD Showcase, School of Medicine, University of Auckland.

Dr Mittal said that while many of the pathophysiological processes associated with acute pancreatitis had already been described, the critical factors that drove the multiple organ dysfunction syndrome and patient outcome had yet to be fully understood.

"During severe acute pancreatitis, there is a reduced blood flow to the intestine due to systemic shock while recent evidence has shown that mesenteric lymph during a period of ischaemia is toxic and can exacerbate acute pancreatitis severity," he said.

"However, the factors in this toxic mesenteric lymph remain unknown so the main focus of my research was to conduct proteomic work in order to identify potentially those toxic factors. Acute pancreatitis is a relatively common condition and in its severe form carries very high morbidity and mortality but despite recent advances in intensive care, the mortality associated with severe acute pancreatitis has not decreased.

"At the same time, there remains no effective prevention or treatment for the condition which means that new ideas and concepts in the pathophysiology need to be explored in order to provide the rationale for future research."

Dr Mittal said his research had revealed that during acute pancreatitis, proteases were able to enter the mesenteric lymph in high concentrations and thus by-pass the liver, directly impacting end organs such as the lungs. He said further research was now being conducted to investigate the use of enteral lymphotropic protease inhibitors in acute pancreatitis.

He also said that other avenues of his research had revealed that during acute pancreatitis there was early mitochondrial dysfunction present in selected end organs such as the lungs and jejunum as early as six hours with work now being done to investigate the use of mitochondrial specific therapies.

Dr Mittal has conducted his research within the Pancreas Research Group, Department of Surgery, University of Auckland under the supervision of Professor John Windsor and Dr Anthony Phillips. He said he was greatly appreciative of the support shown him by the College Fellows both in Australia and New Zealand and the guidance and support shown him by his supervisors.

He said the highlight of his period of dedicated research had been the gift of time.

"I have really enjoyed the opportunity to step out of the hospital and into the laboratory. I found that for the first time since medical school, I could just sit and think. Clinical work tends to be driven by busy schedules, rigid guidelines and little time for philosophy but in the lab I had the freedom to hypothesize, design and carry out experiments under the supervision, of course, of my mentors," he said.

"It has been a wonderful three years and without the financial support I received from the College in the form of these two scholarships I would not have been able to have such an experience. Now I have learned skills that will allow me to become an academic surgeon and guide future surgical Trainees through their PhDs."

Donations needed for the Jimma University Hospital, Ethiopia

If you have any of the following or would like to make a donation to help the people of Ethiopia please email Barry Hicks mpelier1@bigpond.com

- Gowns - linen
- Drapes - linen
- Scopes of various types – oesphagoscope, cystoscope, sigmoidoscope, proctoscopes – rigid sterilizable
- Operating tables 5 needed
- Decent stirrups and arm boards
- Diathermy machines
- De Bakey forceps – straight and angled (a personal like!)
- Head lamp and light source
- Video headlight with light source
- Large viewing screen in a different room – this could be purchased in Ethiopia
- Anaesthetic tubes including guarded.
- Laryngeal masks
- Double lumen tubes
- "Licorice sticks"
- Packs, clean up swabs and gauze
- 3/0 BSS ties for thyroids
- Anaesthetic machines
- FRACS Internet membership
- Some stuff for staff room in OR. –eg electric kettle, cups etc – purchasable in Ethiopia
- Mixter forceps
- Bookwalter retractor
- Hand drill with bits
- Vascular instruments
- Oxygen concentrators.
- Thoracic instruments
- Alligator forceps
- Cuff material for gowns – those in Ethiopia already are all too short
- Silver's knives
- Diathermy plates
- Diathermy probes

Commercial Bank of Ethiopia, Addis Ababa, Account name S.I.M Ethiopia Account number N/T 01704/172498/00 *and indicate that it is for* **Hicks in Jimma**

Trauma Week – September 2009

Adelaide played host to meetings, workshops, presentations and even a dinner where the guests provided the entertainment during trauma week

Daryl Wall
Chair, Trauma Committee

Ian Civil and Russell Gruen at the Gruen Transfer

The College's Trauma Committee's annual meeting/s were held during the International Surgical Week (ISW) in Adelaide in September 2009. This provided an excellent opportunity for the Committee to catch up with their national and international colleagues. One thousand four hundred delegates – 600 Australian – gathered in the City of Churches to attend an exciting and challenging scientific meeting. Along with the Trauma Committee meeting on 9 September, seven other Trauma Sub-Committees held face-to-face meetings during ISW which made for a productive and action-packed week. The days stretched out from 7 am and ran until 11 pm as meetings were squeezed into the busy program.

National Trauma Data Bank workshop: A workshop based on the US National Trauma Data Bank (NTDB), was sponsored, and run, by the American College of Surgeons Committees on Trauma. This was held in recognition for the work done in Australasia on trauma registries and data banks. This meeting developed enormous harmony for administrators and researchers in many countries.

Recognition of Service

Danny Cass, past chair of Trauma Committee, was recognised for his service to trauma and to the College, as Chair of the Trauma Committee from 2005 – 2009. Daryl Wall, current Chair, presented Danny with a commemorative plaque and a Waterford Pen.

Bill Griggs (Trauma Director Royal Adelaide Hospital) was given Life Membership of the Australasian Trauma Society (ATS) for his commitment and dedication to the ATS, and trauma, in Australasia. Ian Civil, past president of ATS, presented the certificate to Dr Griggs.

Trainees Trauma Paper Competition

The Trainees Trauma Paper Competition was held during ISW and delegates were able to attend the presentations of four trauma research papers. Judges Michael Holland, Danny Cass and Grant Christey awarded Andrew Martin the prize for the best trauma paper for his research on Re-defining Shock: Updating Trauma Registries for the 21st Century

Andrew Martin, Trauma Fellow at John Hunter Hospital, has the opportunity of presenting his paper at the United States Residents Papers Competition which is part of the American College of Surgeons Committees on Trauma (ACS CoT) Annual Meeting that is being held in Las Vegas in March 2010.

We wish Andrew the best of luck for his forthcoming presentation in America. This is the last year that the winner of the College Trauma Committee Trauma paper competition is, automatically, able to present their paper at the ACS CoT competition. Congratulations to Andrew.

Gruen Transfer/Trauma Dinner

The Trauma Committee combined with the ATS held a working dinner at the Gallery of South Australia on Wednesday evening 9 September. The evening followed the format of the popular TV show *The Gruen Transfer*.

You may wonder what does 'the Gruen Transfer' mean? It refers to the moment when consumers unwittingly respond to cues in the shopping environment that are designed to disorientate. Factors such as lighting, sounds, temperature and displays interact, leading the customer to lose control of their critical decision making processes. Our eyes glaze over, our jaws slacken, we forget what we came for and become impulse buyers. So if you go into a mall to buy a mop and walk out with a toaster, a block of cheese and a badminton set, then the Gruen Transfer has probably played a role.

Arthas Flabouris, Intensivist and Chair of the Trauma Verification Sub-Committee, convened the evening. In his capable hands all 55 participants were brilliantly fed and watered as well as entertained, informed and challenged. Professor Russell Gruen, Director of the National Trauma Research Institute

"With the impending nationalisation of health in Australia, Kevin Rudd has selected trauma care to be the shining light of the new national health reform/revolution agenda."

at the Alfred, was the host with the most (complete in leopard-skin tux). He ensured that proper procedures were followed and began the event by calling for conflicts of interest. Some interesting declarations were revealed including a reluctant admission of voting for Barack Obama.

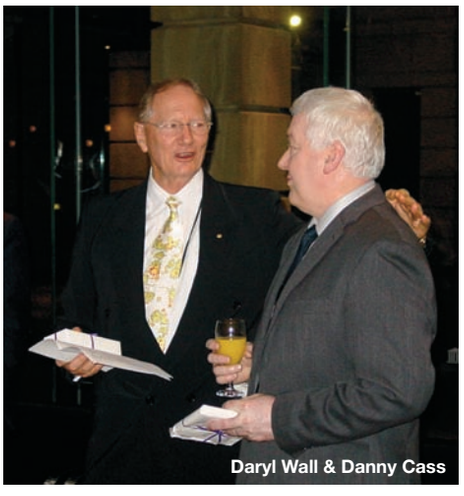
The expert panel addressed issues of key performance indicators and quality improvement programs that are needed for optimum trauma care. Luminaries on the panel included top international trauma surgeons Donald Trunkey, Bill Schwab and Charlie Mock (who was launching a World Health Organisation publication the following day entitled: 'Guidelines for trauma quality improvement programs'). Other panel members were Daryl Wall (Chair Trauma Committee), Zsolt Balogh (Director of Trauma John Hunter Hospital), Trish McDougall (General Manager NSW Institute of Trauma and Injury Management) and Andrea Delprado (Vice-President ATS).

Then came the entertainment and 'selling the un-sellable' – or 'the pitch':

"With the impending nationalisation of health in Australia, Kevin Rudd has selected trauma care to be the shining light of the new national health reform/revolution agenda." The Royal Australasian College of Surgeons Trauma Verification subcommittee, having been identified as industry leaders in being able to deliver on the promises they make (that is because it is the only committee with nurses and physicians on it), are commissioned to perform. We need you to sell trauma performance measures & trauma verification to the masses as the cornerstone of the new health regime set to sweep the nation to Kevin Rudd's Health Care Nirvana.

Team A (Charles Mock, Geneva; Ian Civil, Auckland and Louise Niggemeyer, Glen Waverley) delivered a powerful, effective, and humorous message of why Trauma Verification matters and how it can influence and improve the care of the injured patient.

Team B (Damian McMahon, Canberra; Arthas Flabouris, Adelaide and Maxine Burrell, Perth) performed a lively rap dance which highlighted why, if you're wrapped


Daryl Wall & Danny Cass

around a power pole and see the lights flashing and bells ringing, you want to be taken to a verified Level I Trauma Service – not to the nearest hospital.

After much deliberation from the judges: Danny Cass (Chair, NSW Trauma Committee), Andrew Pearce (president ATS), Stephen Deane (Clinical Chair, Division of Surgery John Hunter Hospital), Julie Christey (dinner guest from Waikato – Not the actress!) and Lyn Journeaux (College Trauma Committee) Team A was declared the winner of the inaugural 'Gruen Transfer prize'.

The evening was a great success and hailed by some as the 'best ever conference dinner'.

Being a New Zealand Younger Fellow

Hard work and moving families across land and sea are all part and parcel of what is ultimately a rewarding career for Kiwi Fellows

Mr Gowan Creamer
NZ Representative
Younger Fellows Committee


Mt Egmont, Taranaki

Richard Page, Chair of the Younger Fellows Committee suggested I write about being a New Zealand Younger Fellow, "you know... how it is different? Maybe?" I am not sure that being a New Zealand Younger Fellow (NZYF) is any different from my Australian counterparts experience so the following description is my generalisation.

Training in New Zealand (NZ) hospitals and gaining Fellowship in the last ten years would seem a suitable definition of a NZYF as well some other demographics; increasingly female, multicultural, often married (with more surgeons marrying other doctors), mid thirties, kids and maybe a family pet or two. We are middle class and in the middle of our lives, usually with one generation alive either side of us.

I became a Younger Fellow through choice. This choice is typically to put aside what I could have now so that the future might be better; 'do the hard yards' now so life can be better later. For New Zealanders this is a part of our national heritage; most Kiwis have ancestors who got on a boat to go to somewhere that, with some hard work, would be better for them and their families. Often they were farmers, carpenters and the like.

The NZ journey to the title 'surgeon' typically starts at school; getting the grades and attending medical school. For Auckland graduates ethics, behavioural science and biculturalism were taught in a multicultural landscape. As junior doctors we applied for basic surgical training and a minimum of five years later we became a Fellow of the Royal Australasian College of Surgeons. During this time we may have married and started a family. By the end of training we can have a significant debt to our families.

Now as Younger Fellows many of us subspecialise; another one to three years of 'not yet having your name over the patient's bed head'. For most New Zealanders this involves crossing an ocean or two. Spouses and children are uprooted and asked, again, to cope with significant change. This time can be financially and socially stressful but also full of fantastic memories. Half way through our lives, we have spent half our lives getting to what feels like the start of our careers.

Most NZYFs work in public initially. By the end of ten years as a Younger Fellow most Kiwis are both public and private surgeons; juggling, helping and competing in the different arenas. Work-life balance is usually 'work–family life' balance rather than 'work-lifestyle' balance.

Practicing in the New Zealand environment means no suing. This means monetary settlements are not legally possible. Indemnity insurance is typically less than $2000 (NZ) per annum. Bad outcomes and complaints have a different, often protracted and stressful, progress through the system.

Starting salaries in public are about half of salaries in Australia; the top tax rate is 38 per cent. We defiantly provide the best public health possible on a shoestring budget.

I guess, like all Younger Fellows, we have multiple requests for our time. Saturday morning sport with the kids; education; committees; developing policies procedures and pathways for hospital and college...while still trying to see patients, organise their operations then follow their recovery; day to day we are very busy. Most NZ departments and NZ colleagues are helpful and supportive in difficult situations likely to arise in a NZYF early career.

I hope my colleagues see this as a broadly accurate picture of life as an NZYF, and that it might help others understand the 'NZ perspective'. I would welcome any suggestions from other Younger Fellows about how the Younger Fellows Committee can support and further represent New Zealanders.

For further information or comments please phone +61 3 9249 1122 or email ally.chen@surgeons.org

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The benefits of living in the country

Don't wait too long to relocate and live a different type of life — the decision will not be regretted

There is a certain symbolic aptness about the decision made by retired New South Wales (NSW) surgeon Mr Geoffrey Pritchard to leave Sydney some years ago to move to the cool high country in the foothills of the Snowy Mountains to grow peonies. An ancient flower, loved for both its beautiful blooms and the medicinal qualities of the roots, it was, after all, named in honour of Paeon, the physician to the gods.

Mr Pritchard said he first saw peonies growing at the University of Washington when he was undertaking medical research in the cool environs of Seattle in America and was so impressed he decided that if he ever fled the city for the bush, he would head for the hills and give it a shot himself.

That day came somewhat earlier than expected when the imminent closure of the Prince Henry Hospital, where he was then based as a gastrointestinal surgeon, galvanised him into action. Then aged only in his early 50s, he was not yet ready to put down the scalpel, so chose a country region where he could still practice as a general surgeon while learning the fine art of peony production.

Now he lives on a 20 hectare property outside the township of Tumut, which lies between Wagga Wagga and Canberra in New South Wales, and has a spectacular view of Kosciusko National Park from his back door.

"At the same time as the Prince Henry was facing closure in the 1980s my work was rapidly changing in terms of the development of diagnostic technology and both factors influenced the decision to leave Sydney," Mr Pritchard said.

"I wanted to find a cold climate farm and I thought Tumut was far enough from the city to avoid the effects of any urban sprawl or the tree-changer phenomenon – at least in my life time – but more important than all of that was that I wanted to help kick along medical services in a rural region.

"I spent some time in Tumut as a child and I have clear memories of my mother having to undergo surgery in our home because of a lack of appropriate services and the difficulties associated with travel and that was the first time I recognised the different quality of health care offered to people in the bush.

"When I first moved here then, I worked out of Tumut Hospital at a time when we had very good GPs able to do the anaesthetics so I could do quite advanced surgery which saved local people both the cost and time of travel and the costs associated with staying in the city."

So passionate did Mr Pritchard become in improving both the health services offered to rural people and the sustainability of rural populations that he became firstly the Mayor of Tumut Shire for ten years, the President of the local Rotary Club, a member of the Bush-fire Brigade and a member of the first board of the NSW Cancer Institute and the Director of Medical Administration in the Southern Area Health Service.

More recently, his efforts in attracting Visy Packaging to set up a state-of-the-art facility in Tumut were recognised when he was appointed to the board of Regional Development Australia–Southern Inland, a group established to advise government on rural job creation.

He has stood as the local Australian Labour Pary candidate in a staunchly conservative area and ran a successful campaign to have all the Emergency Departments in the small rural hospitals of the region given broadband capacity to allow for real time emergency consultations with city specialists.

"It is impossible to live in a region such as this one and not be aware of the difficulties and pressures facing people outside the metropolitan areas. I think members of the medical profession who are well educated, resourceful and articulate have a great deal to contribute to the broader community outside the health

system if, or when, they can find the time and I think we have a responsibility to do that," Mr Pritchard said.

"I found I could not work here and not do my best to help overcome some of these issues, even outside the health field like attracting jobs to the area to try and stem the flow of our young people from the towns to the cities."

Now Mr Pritchard has a dream. In it, he sees the Federal Government taking over the health system, breaking down old state barriers and creating health regions that make sense geographically rather than politically.

Specialists would be appointed to the region rather than to a specific hospital giving them greater autonomy and more scope for private practice which in turn would attract more such specialists to regional areas reducing the on-call load and lack of collegiality.

Then finally, he sees the full establishment of top-flight regional universities to educate and train future professionals without forcing them to leave the bush.

Even Mr Pritchard's peony farm is part

"It is impossible to live in a region such as this one and not be aware of the difficulties and pressures facing people outside the metropolitan areas."

of his future dreaming, having been established to help lead the way for other farmers to overcome the problems of globalisation by growing niche products for niche markets.

"There is no way that small growers can compete with the major agricultural producers but peonies cannot be mass produced. They are an alpine plant and they have to grow outside, you can't grow them in glass houses, they have to be picked at the right time then placed in a cool room at four degrees, then taken to market as soon as possible," he said.

"They are the unofficial flower of China - we have supplied them to the Chinese Embassy in Canberra for their national day in past years - they are particularly popular for weddings and they are beautiful so while it is quite hard work during picking season it is rewarding work."

Mr Pritchard stopped working as a surgeon in 2002 but with all his other interests, retirement does not seem the right word to use for this latest chapter in his life.

Yet he said that while moving out of the fine suburbs of Sydney took a certain courage, he had never regretted it and has one piece of advice to offer other surgeons considering a similar move.

"Don't wait too long to relocate and live a different type of life. It takes time to build credibility and rapport with country people and if you make the change when you're younger rather than older there are many aspects to country life you can get involved in which bring a great sense of reward quite different to that experienced by doing good work in theatre," he said.

Notice to Retired Fellows of the College

The College maintains a small reserve of academic gowns for use by Convocating Fellows and at graduation ceremonies at the College.

If you have an academic gown taking up space in your wardrobe and it is superfluous to your requirements, the College would be pleased to receive it to add to our reserve. We will acknowledge your donation and place your name on the gown, if you approve.

If you would like to donate your gown to the College, please contact +61 3 9249 1248.

Alternatively, you could mail the gown to

The Conferences & Events Department, Royal Australasian College of Surgeons, College of Surgeons Gardens, 250-290 Spring Street, East Melbourne 3002.

The College would like to thank Mr Donald Fleming for the generous donation of of his academic gown.

The Trainee Working Hours Survey

Feedback from current Trainees will be paramount in building regulations for working hours

Greg O'Grady
Training Portfolio Chair &
Matthew Peters
Chair, RACSTA

The working hours of surgical Trainees are under ever-increasing scrutiny. Typical Trainee working hours have already fallen well below the long hours that were endured by previous generations of surgeons, and overseas trends suggest that pressure will continue to build for further regulations on the hours we work.

Many factors are driving and shaping the working hours debate, but perhaps foremost are the issues of doctor fatigue and patient safety. The College has been proactive in this area in recent years, including preparing the College Standards for Safe Working Hours and Conditions for Fellows, Surgical Trainees, and International Medical Graduates guidelines. However, numerous external parties, including political and patient advocacy groups, hospital administrators, and the media are also lending their opinions to the debate. With so many agendas in the arena, the facts regarding the optimal working hours of trainees are at risk of being lost in the fog.

In trying to sensibly navigate the safe hours debate, one problem that we face is that there is actually very little evidence about what is happening at the training coal-face. We don't have an accurate knowledge of the current rostering practices in Australasia, and have little data on whether the impacts of Trainee fatigue are currently being felt. More information is also needed to determine if our rosters are adequately supporting our learning needs, and how trainees feel about their work-life balance.

In response to these needs, the Royal Australasian College of Surgeons' Trainees' Association (RACSTA) has developed a comprehensive survey that will be put to all surgical Trainees of the College this month. This is a particularly important survey, and we are hoping that all trainees will take five minutes out of their busy schedules to complete it. A survey invitation will shortly be sent to all Trainees via an email that provides a link to the online survey site. We need a very high response rate to make this project worthwhile, and encourage everyone to play his or her part in this initiative.

Optimising working hours for Trainees presents a complex balance of safety, learning needs, work-life balance and provision of services. The RACSTA Trainee Working Hours Survey will be a vital contribution to help us move the debate forward to obtain the best result for trainees, our training, and ultimately our patients. We encourage your support.

REGIONAL NEWS

Tasmanian Annual Scientific Meeting

Professor John Thompson, Executive Director of the Melanoma Institute Australia and Professor of Melanoma and Surgical Oncology of the University of Sydney, delivered the Henry Windsor Lecture at the Tasmanian Annual Scientific Meeting held at the Hotel Grand Chancellor, Launceston 2-4 October 2009. The presentation was entitled "Melanoma Update" and Dr Ian Dickinson, Vice President of the College, presented Professor Thompson with the Henry Windsor Medal following the address.


Ian Dickinson & John Thompson


Hung Nguyen & John Thompson at the ASM

1

Strengthening our relationships in Papua New Guinea

The College has the biggest international aid commitment of any of the medical colleges in Australia

In a strong endorsement of the decision made last year by the College to refocus its aid program to Papua New Guinea (PNG) away from the provision of visiting specialist teams toward capacity building and mentoring, two PNG surgeons this year qualified in their specialties in paediatric surgery and urology.

Dr Benjamin Yapo became the third Paediatric surgeon to qualify in PNG, his training funded through the Surgeons International Award and supported by Mr David Croaker, Mr Albert Shung, Mr Paddy Dewan and PNG paediatric surgeons Mr McLee Matthew and Okti Poki.

Dr Timmy Tingnee qualified as PNG's second urologist, his training in Australia supported by the Rowan Nicks Pacific Islands Scholarship, the mentoring of Mr Don Moss and Mr Andre Lalak from Australia and in his home country by PNG's first urologist Dr Osborne Liko.

Over the same time period, the local provision of cardiac surgery was also profoundly boosted by the return of surgeons Dr Noah Tapaua and Dr Lister Lunn and anaesthetist Arvin Karu following their training in Australia and India.

With 2009 now being described as the start of a new era in the relationship between the College and PNG, a milestone was also reached in June when Dr Tapaua conducted ten open-heart surgeries with the assistance of Dr Arvin Karu, the first such surgeries to have been conducted by a local team under the umbrella of the Operation Open Heart program.

Dr Tapaua, from the island province of New Ireland, chose to specialise as a cardiothoracic surgeon in 2006 because of the lack of such services in PNG. After receiving the Surgeons International Award in 2007, he arrived in Melbourne to begin his training at the Geelong Hospital under the supervision of Mr Morteza Mohajeri.

He completed his training attachment in early 2009 and is aiming to become the first surgeon-educator of cardiothoracic surgery in PNG. He has now been nominated for the Rowan Nicks Scholarship to help fund his further training in India.

Speaking of his recent achievement in conducting the open heart surgeries, Dr Tapaua described it as a "significant step forward both personally and for the country" and gave particular thanks to the College and the cardiothoracic unit at Geelong Hospital.

He said that before the Operation Open Heart team, funded by AusAID, arrived in late May, he had also led the local team including anaesthetist Dr Karu in performing 16 Patient Ductus Arteriosus ligations.

"The support of the College has been tremendous in getting to this level. With the further support of the College, my colleague Dr Lister Lunn and Dr Karu were also sent to India for training in cardiac surgery and anaesthesia," Dr Tapaua said.

"Currently we don't have a cardiothoracic unit but we are working toward establishing one by early next year to allow us to provide

this vital surgery for the 6.5 million people in PNG. At present we are not there yet because we still need specialist cardiac equipment including a bypass machine and we are yet to train one or two perfusionists and intensivists. However, while we will still depend on outside visits we have started on the right path."

The milestones made in the expansion of surgical services in PNG in 2009 were achieved under the new programme model known as the Health Education and Clinical Services Program (HECS) which was established to allow for greater PNG control in deciding areas of medical need. This program is funded by the Australian Government through AusAID.

Designed to replace and combine the PNG Tertiary Health Services (THS) Project and the Medical School Support Project, HECS will be run by a PNG management board, headed by the Dean of the Medical School, which will then advise the College as to which specialist visits or the type of educational assistance are required.

According to the Chair of the College's International Committee Professor David Watters, the changes were made to reflect the huge advances made in countries such as PNG and Fiji in the education and training of their own specialist surgeons.

He said 70 general surgeons had been trained in PNG since 1979 and that there were now five local orthopaedic surgeons, three head and neck surgeons, two urologists, one neurosurgeon, three paediatric surgeons, two cardiothoracic surgeons, ten ear nose and throat surgeons and ten ophthalmologists, almost all of whom have continued to work in PNG, with some now in practice in the private sector.

"This has been a fantastic achievement for surgery in PNG and is a credit to the College and the volunteers who have given their time and support," he said.

"The provision of Rowan Nicks Scholarships and the Surgeons International Award have also been of great benefit in enhancing the training opportunities available to PNG trainees and surgeons."

Professor Watters said that while the College was still managing the specialist team visit (formerly PNG THS) component of the HECS program during its initial transition phase, full control would devolve to PNG next year which could see a further refining in the type of assistance provided by the College.

"As the management board takes over next year the type of assistance required by the College could further change. There is a great need there for the development of other specialties such as cardiology, anaesthesia, oncology and obstetrics so the focus may move away from surgery for the simple reason that the surgical aid programmes have worked so well," he said.

1. Launch of the HECS Program (Port Moresby): Professor Sir Isi Kevau (Dean SMHS & HECS Program Director), Sir Puka Temu (PNG Deputy Prime Minister & Minister for Lands & Physical Planning & Mining), Professor Ross Hynes (Vice Chancellor UPNG), Dr Paison Dakulala (Deputy Secretary NDoH), Dr Varage Laka (Specialist SMO, NDoH). **2.** Dr Adolf Saweri (Chairperson Clinical Sciences Division, SMHS & UPNG), Professor Sir Isi Kevau, Professor Ross Hynes, Sir Puka Temu, Mrs Robin Scott Charlton (Chief of Operations AusAID). **3.** Noah Tapua **4.** Ben Yapo **5.** Timmy Tingnee with Grace Warren

"However, the population of PNG has almost doubled since 1989 which means that the delivery of services to regional areas remains a huge challenge which is why team visits will still be needed.

"Yet we hope that each team visit has an educational component and also that each team has PNG members if not a PNG leader. There also remains a great and on-going need for academic support and in future the College could be asked to focus on the provision of examiners, thesis supervisors and mentors."

Professor Watters particularly praised the efforts of David Hamilton and external examiner Hamish Ewing in supporting the MMed program. He said the College had shown a considerable commitment to medical education in PNG. Last year, the President, Professor Ian Gough attended and addressed the Annual PNG Medical Society Symposium while the College was represented by Vice-President, Mr Ian Dickinson in September this year.

He said that more than one million of AusAid funding has been for the provision of specialist visits to PNG and hopes for more targeted visits under the new model with a stronger emphasis on skills transfer.

"While the College has a place on the advisory group where strategic decisions are made and also on the co-ordinating group which implements the decisions, we will take less of a leading role in terms of the services we provide," he said.

"That's a good thing. All these changes reflect our support for the desire that medical professionals in PNG take on more leadership and that in turn reflects how successful and important has been the contribution made by countless Fellows over many years in improving surgical services to the country.

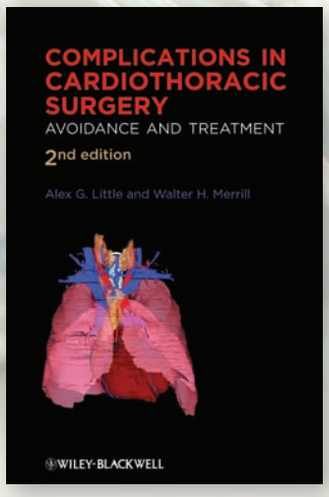
"Since the mid-1990s, our international aid programs have all been based on an evolving approach which recognises each particular country's needs and aspirations and in the case of PNG it was clear that capacity building was the best contribution we could make now and into the future. The surgeons who have qualified this year are a testament to that approach.

"The College has the biggest international aid commitment of any of the medical colleges in Australia and I would even expect that we could be asked to provide other Colleges and health bodies with advice and guidance on the provision of health services and education because of the success of our partnership with PNG over more than three decades."

The Surgeons' Bookclub

Welcome to The Surgeon's Book Club

Highlighted in this months issue are recent and new titles from across the spectrum of books available from John Wiley & Sons.



Book of the Month New
20% Discount

Complications in Cardiothoracic Surgery: Avoidance and Treatment, 2nd Edition
Alex G. Little, MD, Walter H. Merrill, MD
9781405181037 | Hbk | 496 pages | November 2009,
~~AU$215.00~~ / **AU$172.00**

Drs. Little and Merrill draw on their expertise in general thoracic and cardiac surgery in this new edition, to review tracheobronchial operations, lung volume reduction operations, lung transplantation, minimally invasive esophagectomy, pleural operations, revascularizations, myocardial operations, and aortic and great vessel operations. For each operation, leading practitioners provide specific advice on what to be aware of to prevent complications – and how to manage them if they do occur.

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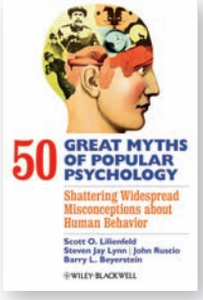
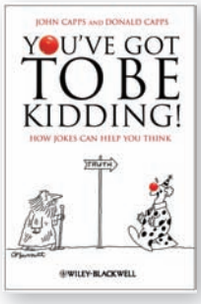


50 Great Myths of Popular Psychology: Shattering Widespread Misconceptions about Human Behavior
Scott O. Lilienfeld, Steven Jay Lynn, John Ruscio, Barry L. Beyerstein
9781405131124 | Pbk | 352 pages | September 2009
~~AU$37.95~~ / **AU$32.26**

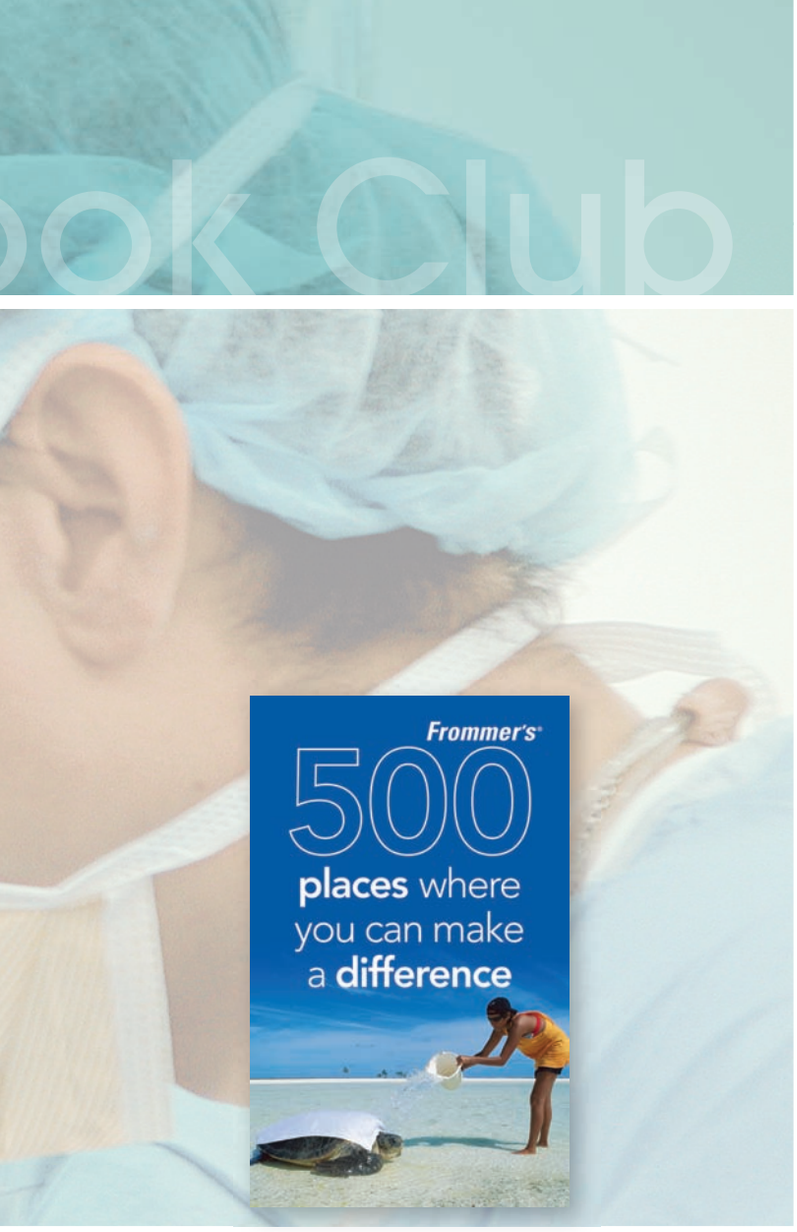
50 Great Myths of Popular Psychology uses popular myths as a vehicle for distinguishing science from pseudoscience. Organized around key topic areas of modern psychology such as brain functioning, perception, development, memory, emotion, intelligence, learning, personality, mental illness, and psychotherapy, this book will help students and laypersons to critically evaluate the information and misinformation that is generated by popular psychology.

- Provides a "mythbusting kit" for evaluating folk psychology claims in everyday life.
- Includes over 200 additional psychological myths for readers to explore Contains an Appendix of useful Web Sites for examining psychological myths.
- Features a postscript of remarkable psychological findings that sound like myths but that are true.



You've Got To Be Kidding!: How Jokes Can Help You Think
John Capps and Donald Capps
9781405196642 | Pbk | 144 pages | August 2009
~~AU$37.95~~ / **AU$32.26**

You've Got to Be Kidding!: How Jokes Can Help You Think focuses on a single, core issue at the heart of philosophy: our ability to think critically. The authors, a father and son team of distinguished professors, aren't kidding around when they show us that jokes illustrate the various ways in which the thinking process goes awry. You've Got to Be Kidding!: How Jokes Can Help You Think is a thoughtful and accessible analysis of the ways jokes illustrate how we think critically - and that's no laughing matter.



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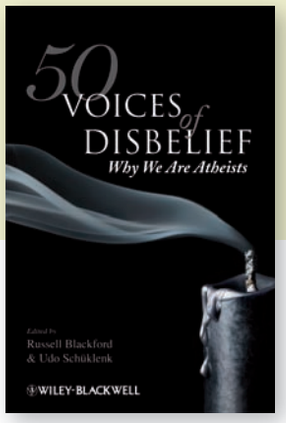

Frommer's 500 Places Where You Can Make a Difference
Andrew Mersmann
9780470160619 | Pbk | 480 pages | October 2009

~~AU$32.95~~ / **AU$28.00**

A brand new addition to the highly popular Frommer's 500 Places series, this book offers readers a range of inspirational and motivational volunteer holidays around the world. This new trend of combining holiday travel with volunteer opportunities offers an experience that allows travellers to explore a culture in greater depth, make new friends and come home feeling like they have learned and benefited even more than the people they helped. The book offers a broad range of volunteering ideas to cater for every individual, from working with animals, scientific research, healing the environment, building communities, improving health and teaching, through to sport and getting political. This book also includes a special section on child friendly trips that will help the whole family open it's eyes up to the world beyond our front door.
Australian entries include:
• ten food banks in popular destinations — VicRelief Food Bank, Melbourne
• coaching — coach tennis at a top tennis academy, Perth
• ten ways to keep memories alive, oral history projects — Mosman Local Studies Library, Sydney
• festivals and tournaments — Australian Blues Music Festival, Goulburn.

50 Voices of Disbelief: Why We Are Atheists
Russell Blackford and Udo Schüklenk Australian Authors✲
9781405190466 | Pbk | 360 pages | October 2009

~~AU$39.95~~ / **AU$33.96**

50 Voices of Disbelief: Why We Are Atheists presents a collection of original essays drawn from an international group of prominent voices in the fields of academia, science, literature, media and politics who offer carefully considered statements of why they are atheists. Features a truly international cast of contributors, ranging from public intellectuals such as Peter Singer, Susan Blackmore, and A.C. Grayling, novelists, such as Joe Haldeman, and heavyweight philosophers of religion, including Graham Oppy and Michael Tooley. Contributions range from rigorous philosophical arguments to highly personal, even whimsical, accounts of how each of these notable thinkers have come to reject religion in their lives

Conference Diary Dates

Here are some dates for some of the surgical conferences coming up. If you are aware of any other meetings that you would like to see added to the College website Conferences page, please let us know by email to College.library@surgeons.org. Links to the Conference websites or further information can be found on the Conference listing on the College website www.surgeons.org (under Fellows, Resources for Surgeons).

Australia/NZ

- Royal Australasian College of Surgeons Annual Scientific Congress
  4 - 7 May 2010 / Perth WA AUSTRALIA

Overseas

- 2nd International Conference on Surgical Education and Training
  13 - 14 May 2010 / Dublin IRELAND

Cardiothoracic Surgery

Australia/NZ

- Annual Scientific Meeting of the Thoracic Society of Australia & New Zealand
  19 - 24 March 2010 / Brisbane QLD AUSTRALIA

Overseas

- Society of Thoracic Surgeons 46th Annual Meeting
  25 - 27 January 2010 / Fort Lauderdale FL USA

General Surgery

Australia/NZ

- Austrauma 2010
  12 - 13 February 2010 / Sydney NSW AUSTRALIA
- New Zealand Association of General Surgeons Annual Meeting
  26 - 28 March 2010 / Tauranga NEW ZEALAND
- General Surgeons Australia Annual Scientific Meeting
  17 - 19 November 2010 / Gold Coast QLD AUSTRALIA

Overseas

- American Society for Reconstructive Microsurgery Annual Meeting
  9 - 12 January 2010 / Boca Raton FL USA
- 4th International Hokkaido Trauma Conference
  17 - 23 January 2010 / Rusutsu JAPAN
- International 28th Course for Percutaneous Endoscopic Spinal Surgery and Complementary Minimal Invasive Techniques
  28 - 29 January 2010 / Zurich SWITZERLAND
- Annual Meeting of the Society of Surgical Oncology (SSO)
  4 - 7 March 2010 / St Louis MO USA
- American Society of Breast Surgeons Annual Meeting
  29 April - 2 May 2010 / Chicago IL USA
- Trauma Association of Canada Annual Scientific Meeting
  6 - 7 May 2010 / Halifax Nova Scotia CANADA
- American College of Colon and Rectal Surgeons Annual Meeting
  15 - 19 May 2010 / Minneapolis MN USA
- 11th European Congress of Trauma and Emergency Surgery
  16 - 19 May 2010 / Brussels BELGIUM

Neurosurgery

Australia/NZ

- Spine Society of Australia Conference
  8 - 10 April 2010 / Christchurch NEW ZEALAND
- Neurosurgical Society of Australasia Annual Scientific Meeting
  30 September - 2 October 2010 / Sunshine Coast QLD AUSTRALIA

Overseas

- 10th Annual Canadian Spine Society Meeting
  10 - 13 March 2010 / Alberta CANADA
- American Association of Neurological Surgeons Annual Meeting
  1 - 5 May 2010 / Philadelphia PA USA

Orthopaedic Surgery

Australia/NZ

- Spine Society of Australia Conference
  8 - 10 April 2010 / Christchurch NEW ZEALAND
- Australian Orthopaedic Association Annual Scientific Meeting
  10 - 15 October 2010 / Adelaide SA AUSTRALIA

Overseas

- American Academy of Orthopaedic Surgeons Annual Meeting
  9 - 13 March 2010 / New Orleans USA
- 10th Annual Canadian Spine Society Meeting
  10 - 13 March 2010 / Alberta CANADA
- 10th Annual AAOS / OTA Orthopaedic Trauma Update
  8 - 11 April 2010 / Orlando FL USA

Otolaryngology Head and Neck Surgery

Australia/NZ

- 63rd Annual General and Scientific Meeting of the New Zealand Society of Otolaryngology Head and Neck Surgery
  2 - 5 March 2010 / Paihia Bay of Islands NEW ZEALAND
- AAFPS Conference 2010 'Rhinoplasty and Lasers : the cutting edge'
  26 - 27 March 2010 / Sydney NSW AUSTRALIA
- ASOHNS 2010
  27 - 31 March 2010 / Sydney NSW AUSTRALIA

Overseas

- AHNS Annual Meeting
  28 - 29 April 2010 / Las Vegas NV USA
- Canadian Society of Otolaryngology - Head and Neck Surgery Annual Meeting
  23 - 26 May 2010 / Niagara Falls ON CANADA

Paediatric Surgery

Australia/NZ

- ANZAPS Annual General Meeting
  5 May 2010 / Perth WA AUSTRALIA

Overseas

- American Pediatric Surgical Association 41st Annual Meeting
  16 - 19 May 2010 / Orlando FL USA

Plastic and Reconstructive Surgery

Australia/NZ

- Oculoplastic and Breast Symposia Satellite Meeting
  14 - 17 January 2010 / Kingscliff NSW AUSTRALIA
- AAFPS Conference 2010 'Rhinoplasty and Lasers : the cutting edge'
  26 - 27 March 2010 / Sydney NSW AUSTRALIA
- ASPS Annual General Meeting
  5 May 2010 / Perth WA AUSTRALIA

Overseas

- IFPRAS 15th World Congress
  29 November - 3 December 2009 / New Delhi INDIA
- BAPRAS Winter Scientific Meeting
  2 - 4 December 2009 / London ENGLAND
- American Society for Reconstructive Microsurgery Annual Meeting
  9 - 12 January 2010 / Boca Raton FL USA
- American Burn Association 42nd Annual Meeting
  9 - 12 March 2010 / Boston MA USA
- EURAPS 21st Annual Meeting
  27 - 29 May 2010 / Manchester ENGLAND

Urology

Australia/NZ

- Urological Society of Australia and New Zealand 63rd Annual Scientific Meeting
  21 - 24 February 2010 / Perth WA AUSTRALIA

Overseas

- 42nd Annual Duke Urologic Assembly
  25 - 28 March 2010 / USA
- 25th Annual EAU Congress
  16 - 20 April 2010 / Barcelona Spain

Vascular Surgery

Australia/NZ

- Australia and New Zealand Society for Vascular Surgery - Vascular 2010
  2 - 5 October 2010 / Gold Coast QLD AUSTRALIA

Overseas

- Vascular Annual Meeting
  10 - 13 June 2010 / Boston MA USA

Are the streets becoming more violent?

Hospital admissions for assault have increased dramatically in the past few years. How can we stem the tide?

Daryl Wall
Chair, Trauma Committee

Judging by the nation's headlines, our streets have become more violent and booze is to blame. "One in five hit by alcohol violence". "Alcohol-related street violence in Wagga Wagga. What can be done?" Our politicians are responding. The Queensland Parliament's Law, Justice and Safety committee is looking into alcohol-related violence. The Prime Minister is on board 'Don't drink, just think': Rudd backs Australian Football League anti-violence campaign". Victorian orthopaedic surgeon Dr Bruce Love wrote to the Trauma Committee recently highlighting his concerns for an apparent rise in penetrating trauma. As surgeons commonly manage the medical consequences of often brutal acts, it is natural that we ask: what can be done to prevent them?

Some of the facts

Overall, police statistics show crimes against the person in various jurisdictions have remained stable or have fallen slightly in the last two to three years. However, delving a little further into the data, the number of hospital admissions for assaults has increased dramatically.

A report from the Victorian Trauma Registry reports a significant increase in the incidence of major trauma assault between 2001 and 2007 where the incident of major trauma assault doubled from less than two per 100,000 population to over four. Interestingly, rates of penetrating trauma have remained relatively stable, perhaps as a result of stricter firearm legislation and restrictions on the sale of knives and other weapons, however it states:

"....of concern is the substantial increase in serious assault-related blunt trauma injury. Not only was blunt trauma more common than penetrating trauma, but it also resulted in higher rates of inpatient rehabilitation and poorer long-term outcomes for patients; in addition, it was associated with high rates of serious head injury."

Surgeons are therefore now seeing more serious and severe blunt trauma assault victims in our major trauma centres

Involvement of alcohol

Injuries linked to alcohol have remained high. Nationwide, alcohol-involved road trauma caused over 32 per cent of all alcohol-related acute deaths (which includes deaths due to alcohol poisoning) while alcohol-involved assault and other injury caused 49 per cent of alcohol-related acute hospitalisations. The high percentage of assaults (including homicide) where both the victim and perpetrator are alcohol-affected remains significant and has increased despite reasonably stable levels of per capita alcohol consumption between 1993/94 and 2000/01. Whilst drink-driving countermeasures have been effective, the case for interventions to reduce the incidence of non-road trauma is less clear. Recent evidence suggests the use of increasing alcohol taxation, regulating availability, partial or complete banning of alcohol advertising (particularly to younger people), more intensive enforcement of random breath testing and lowering the legal blood alcohol concentration level, with brief interventions by primary care physicians, could achieve a 48 per cent reduction in alcohol-attributed deaths and significant reductions in the social cost of alcohol-related harm.

It has been suggested that the increase in the number of licensed venues in Victoria is a significant factor in the steady rise in assaults near these venues over the last few years and the State Government is moving to combat the problem by introducing tougher new legislation. In New South Wales, the Government is attempting to change the culture of alcohol use by implementing many of the key recommendations made during the New South Wales (NSW) Summit on Alcohol Abuse in 2003. Outstanding research conducted in NSW provides evidence that strict administration of club hours and administration of club strategies (eg. fining companies for serving inebriated patrons), has been associated with a dramatic reduction in inter-personal violence. This research provides strong evidence that alcohol excess is a central factor in interpersonal violence and that community excesses can be controlled by supervising and policing all night clubs.

Other factors?

While the significance of alcohol as a factor associated with assault is well documented, it is not the only factor. Drug use (particularly methamphetamines) has received particular attention and a specific government response. A fracturing of social mores is also cited as contributing to our problem.

''Is it a problem with education? A lack of respect for community and fellow members of society? Are they divorced from spiritual connections, are they not getting adequate education about how to behave in school and from their parents? I think it is all of these things" suggests Jeffrey Rosenfeld, Neurosurgeon at Melbourne's Alfred hospital.

The solutions?

The solutions are not obvious. No single strategy presents itself as able to combat the problem. Australia's love affair with drink is not a recent phenomenon. Certainly the availability of alcohol in city streets has increased since the liberalisation of licensing rules in the '80s and '90s. Some favour an enforcement approach with New York's zero tolerance policing policy often cited. It can be argued that other United States cities with different policing models experienced similar declines in crime at the same time. The less coercive community policing model embraced by cities such as Chicago also experienced a decrease in violent crime.

The Trauma Committee is looking for strategies that work, policies based on sound research that could help stem the tide of trauma assault. We would be pleased to hear from any member of the College community with their ideas for positive change.

monique.whear@surgeons.org

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Tsunami relief effort

Lessons were learned from the Banda Aceh disaster and were behind the quick speed of arrival of aid to Samoa

In a remarkable effort of logistics and both national and international co-operation, a team of surgeons, emergency physicians and anaesthetists from South Australia and Queensland were flown into Apia, the capital of Samoa, within one day of the September tsunami that claimed the lives of 143 people.

Later followed by teams from Victoria, NSW and New Zealand, the initial group comprised Orthopaedic Surgeon Mr Rob Atkinson, General Surgeon Mr Keith Towsey and Plastic Surgeon Mr Peter Riddell.

All three surgeons are, or were, reserve officers in the Defence Forces and all have had previous experience treating the wounded in major humanitarian medical emergencies including the tsunami in Banda Aceh, Indonesia, in 2004 and the earthquake in Sumatra in 2005.

This time, however, with the tsunami hitting the opposite shore of the main island leaving Apia virtually untouched, they were able to operate in a crowded but functioning hospital, with a temporary tsunami ward having been established prior to their arrival. Fifty casualties, including both local residents and foreign tourists, had been triaged and given initial treatment when the team arrived on the afternoon following the tsunami. In an endorsement of their skills and effort, all those patients treated survived.

Describing their experience in Samoa, the surgeons praised the co-ordination of the aid mission and the speed of their arrival and suggested that both were the result of lessons learned in the aftermath of the Banda Aceh disaster.

Describing the wounded as looking like they'd been "churned in a massive, dirty washing machine", Mr Rob Atkinson, from South Australia, said the priority upon their arrival was to ensure the deep cuts and abrasions caused by tin, coral and rocks did not become infected.

He said that of the 50 patients placed in the tsunami ward, 20 were deemed to require surgery with four priorities chosen to take to theatre that first night with the surgeries beginning at 6pm and ending at 10pm.

"There were three available theatres which had been worked extremely hard by the local surgeons since the tsunami hit on the Tuesday morning. Those patients given immediate treatment had suffered very deep gashes which had been infected with spreading necrosis, gangrene and one abdominal necrotising fasciitis," Mr Atkinson said.

"The surgery was basic principles of extensive debridement, irrigation and leaving wounds open for delayed primary closure or split skin grafting or further debridement depending on progress."

In the days following, the team worked 18-hour shifts, conducting surgeries that took from an hour up to four hours, which also enabled the local staff to get some sleep.

Mr Atkinson said one of the dilemmas facing the surgeons involved not only deciding the priority of patients in need but also deciding whether the injured tourists needed emergency treatment rather than being immediately evacuated to their countries of origin.

"Often in circumstances such as this the tourists don't have local immunity so their wounds can quickly become infected. Therefore we faced the challenge in Samoa of identifying the tourists who needed emergency treatment prior to flying out given the time and distance involved because a necrotising fasciitis can easily progress," he said.

"Some fairly difficult decisions had then to be made because it was clear that the tourists had a greatly reduced resistance to infection compared to the local people who obviously had developed some immunity from exposure to local bacteria."

Mr Atkinson not only praised the skills and commitment of the visiting team of surgeons but also that of the Samoan hospital staff, particularly given that many had been personally affected by the disaster.

"All my colleagues working in Apia during this emergency had impressive surgical skills. They used skeletal traction for fractured femurs of which I treated three with enormous help from local Registrars, one of whom even went home to get some rope," he said.

"It was a privilege to work with people of this quality whose community had been so hard and so tragically hit."

General Surgeon Mr Keith Towsey, a Captain in the Australian Army Reserve and a member of the Burns and Trauma Unit at the Royal Brisbane Hospital, had not long been home from serving in Afghanistan when he got the call to go to Samoa.

A member of the 16-person team from Queensland which also comprised two emergency physicians, one anaesthetist, and two public health physicians, he said almost all the patients deemed to require surgery were treated within 48 hours.

"Some patients had already had their wounds stitched shut and they had to be brought back into theatre to have their wounds debrided," Mr Towsey said.

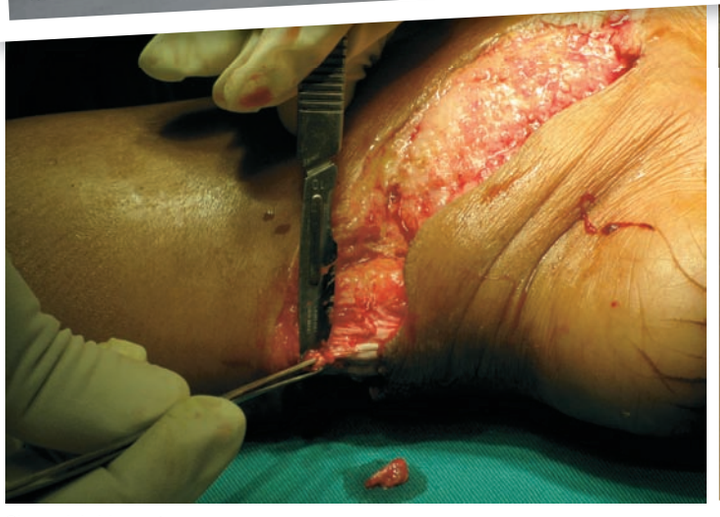
"This, the need for debridement and drainage, seems to me to be a lesson that must be learnt and re-learnt after every disaster and every war because while the wounds may not initially look too bad you can almost guarantee that each one will become infected without it. But that is not a criticism of the local surgeons, you do what you can in circumstances such as these and the local staff had done a fantastic job."

Mr Towsey said he was particularly impressed with the ability of the team from South Australia and Queensland to work so well and co-ordinate their skills and resources so quickly.

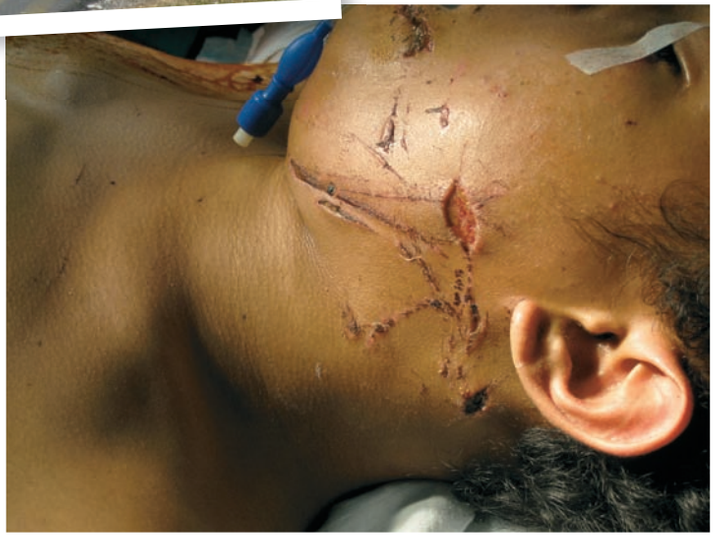
"This was a civilian mission which was appropriate under the circumstances given Australia's relationship with Samoa and I was impressed with the co-ordination involved

The Freedom Bird which took the medical teams home

"All my colleagues working in Apia during this emergency had impressive surgical skills."



Sharp debridement



A cut face from the tsunami

outside a military framework," he said

"In particular I was impressed with the ability of different people from different departments from different state systems with different skills to combine those skills so well and so quickly to do what needed to be done."

Mr Towsey said that some patients treated during the team's four-day mission may need plastic surgery in the future but that none of those treated had lost limbs because of infection. And he said that while the smell of the temporary morgue set up in the hospital precinct became overwhelming in the heat of Samoa, the people and the facilities had more than compensated.

"The Samoans welcomed our help with open arms and are wonderful, pragmatic people. And while the sight of body bags and understanding the scale of the tragedy were confronting, walking into a well run, well organised hospital always helps a lot even for the simple reason that it is such a familiar environment," he said.

Plastic Surgeon Peter Riddell, a Captain in the Army Reserve, said he had only 40 minutes to get on the plane after the initial phone call asking him to go to Samoa leaving him only the time to pick up the emergency kit he has kept packed and ready since his work in the Banda Aceh disaster and a change of clothes.

He said that after Banda Aceh he had a fair idea of the work that lay ahead, in particular peripheral limb injuries and infected lacerations.

"It is useful in disasters like this one to have someone skilled in the treatment of peripheral limb injuries and I worked across the three theatres in the first day or two. On the first day we did only debridements and while there was a push to get tourists out immediately we were concentrating on ensuring that people lived by dealing with the infections first," he said.

"Many of the wounded will subsequently require skin grafts rather than direct delayed wound closure and there were three patients likely to require major flap reconstruction.

"Fortunately, the limited number of casualties and the early surgical response allowed a more limb conserving approach in this particular disaster."

Mr Riddell described the aid mission as "brilliantly done, very quick and very good".

"I applaud the Samoan authorities for calling for assistance so early and the Australian authorities for moving so quickly, both of which I think were lessons learned from Banda Aceh."

LETTERS TO THE EDITOR

Tutorial tips for Trainees

Further to the article in the July *Surgical News* by Steve Leibman of the Younger Fellows Committee with regards to poor attendance by Trainees in structured formal teaching, we would like to report our experience with a particularly successful programme at the Royal Melbourne Hospital and the reasons for its success. For three years we have been running a programme that commenced as the Basic Surgical Training Tutorial Programme but has now become the Junior Surgical Training Programme. It is open to all interns, residents and junior registrars interested in a career in surgical training, as well as the Surgical Education and Training (SET) 1 Trainees. It has been very successful over the last three years, with between 15 and 30 attendees at each tutorial. We would like to outline what we believe to be the reasons for the success.

The tutorial is fortnightly at 6.00pm and each fortnight a different surgical specialty is highlighted. Two of the residents are nominated to speak each week. The topic chosen is relevant to the specialty of the week and is a short, sharp, overview of that topic. The resident is limited to ten PowerPoint slides and fifteen minutes for their presentation. Each week a consultant from the relevant specialty attends as a visitor to make comment on the presentation and generate discussion. Thus, the tutorials are relevant, run to time, light-hearted and become part of the overall " Esprit De Corp" of the surgically interested doctors in the hospital. (It also helps that we provide beer and pizza for each meeting). As part of a coordinated programme we also arrange, at the relevant times of the year, forums for career advice, practice for SET interviews and applications and the opportunity to teach medical students in the Surgical Students Society at the Royal Melbourne Hospital (RMH) Clinical School.

Frequent reminder e-mails and encouragement to attend have been helpful.

Thus the key elements of the successful programme have been:

1. Short, relevant, practically focused topics.
2. Rostering the residents themselves to present.
3. Keeping the tutorial interactive and lighthearted.
4. Providing beer and pizza to create a social atmosphere.
5. Including the tutorials in a more broad program for the junior doctors that are interested in surgery.
6. Embedding this programme in the surgical life of the hospital with encouragement and frequent reminders.

Hopefully this will be helpful for other programmes.

Yours sincerely,
Kate Drummond, MD, FRACS
Neurosurgeon, RMH
Director Junior Surgical Training
Andrew Kaye, MD, FRACS
Professor of Surgery
University of Melbourne
Neurosurgeon, RMH

Gratitude for research

I must congratulate Wyn Beasley on a superbly researched article in the June edition on Winston Churchill. It does reveal advanced scholarship. In response to my Coates article in April of this year, I feel some what humbled by this excellent overview about the history of the tank. My information seems trite in comparison but it came from a television series on Winston Churchill's bodyguard Thompson and the snippet about the tank was only mentioned in passing.

Kind Regards,
Felix Behan
Plastic Surgeon

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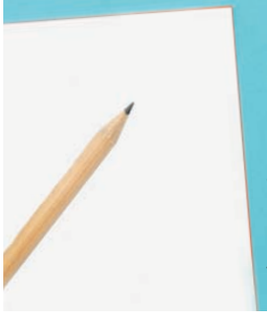
- How to conduct the examination
- What you need to document and why
- Communication, report format, written expression, addressing the needs of the referrer and the patient
- Critical thinking, decision making and bias
- How to distinguish between causality vs predisposition, is it truly work-related?
- Pre-existing conditions; acceleration, aggravation and exacerbation
- Testing the evidence and procedural fairness



CONTINUING PROFESSIONAL DEVELOPMENT
An application with the RACS CPD Program is pending.

For more details of this course and on line registration visit:
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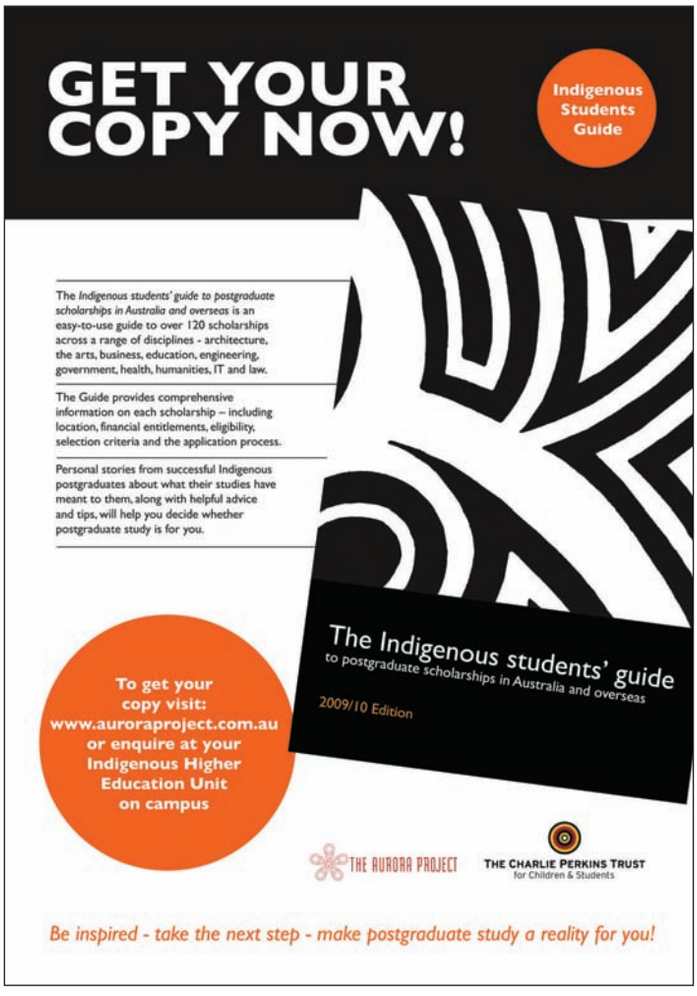
Trainees	325	350



African Purpose

General surgeon Jenny Wagener and her family have moved to Tanzania from New Zealand to work voluntarily and make a difference

Jenny Wagener with nurses on the ward

An elderly Maasai lady presented to Selian Hospital, in Arusha, Tanzania, with five days of abdominal pain and vomiting. On examination she was found to have generalised peritonitis. At laparotomy she had a closed loop obstruction secondary to an adhesion. The necrotic bowel looked several days old and had perforated freely into the abdomen. Throughout the operation the lady was hypotensive. This was a case where you felt the patient was unlikely to survive the night following the operation, yet the next day she was up and walking around and was discharged from hospital some time later.

Dr Jenny Wagener has seen this repeated many times at Selian Hospital: Maasai people walking to the hospital with acute abdomens that have been going on for days and then making remarkable recoveries.

Jenny is a New Zealand trained general surgeon who has moved to Tanzania (long term) to work voluntarily at the Selian Lutheran Hospitals. She and her husband, both New Zealanders, have been passionate for years about going to Tanzania to train the local people in their respective areas of expertise to see Tanzania progress. They moved to Arusha two years ago with their young children.

Selian Hospital started when a Maasai man gifted the Lutheran Church some land so that they could build a hospital, which would provide health care for his people. It started out as a dispensary (a clinic that gave out medicine and had few beds for overnight stays) and has gradually expanded. Ten years ago, the surgical services opened under Dr Paul Kisanga, a Tanzanian trained general, orthopaedic and urological surgeon. He continues to spearhead the surgical department.

"Often people do not come due to superstitions such as the belief that cutting into a cancer will kill you."

Eight years ago they started work on a second hospital, to be located in the middle of Arusha. Due to delays, so common in Tanzania, this hospital was opened at the beginning of this year. The purpose of the new hospital was to be a centre that could offer a vastly improved standard of health care to the people of Arusha.

Overall the healthcare in Tanzania is very poor. The government spend approximately US$2 per person per year on health care. There are various levels of doctors from those who are trained for three years, in clinical medicine, to MBChB trained doctors through to specialists.

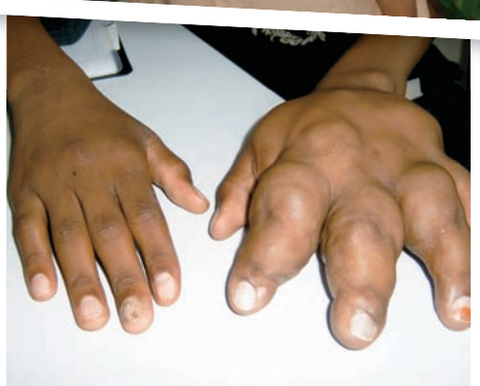
Often diagnoses are made on probability rather than on signs and symptoms due to lack of expertise and poor diagnostic equipment. As an example, many sick people get wrongly diagnosed with malaria just because it is so common.

Jenny works part time, due to her commitment to her young family. This involves a weekly clinic, seeing between 30-60 patients with a variety of conditions, from hydatids to goitre, to benign prostatic hypertrophy. Basic radiology and limited laboratory investigations are available. She has a weekly operating list which again is very varied and includes diagnostic endoscopy and basic laparoscopy. Though there may be 13 patients on the list, often patients do not turn up for their operation. This can be for a variety of reasons from family funerals to the mud being too thick to allow travel. Often people do not come due to superstitions such as the belief that cutting into a cancer will kill you. Or the family who refused to amputate the non-functioning hand of their son, which continued to expand from an apparent venous malformation, due to the fact that the house had experienced ongoing financial success since his hand became disfigured.

The hospitals are very dependent on


The Wagener family


ALMC, Arusha Lutheran Medical Center


The hands of the boy that the parents wouldn't amputate


Selian Lutheran Hospital

equipment that is donated from the West. This often leads to the use of suboptimal equipment and material during operations such as using a glove over a laparoscopic port as there are no toilet seats donated. Anaesthetics are performed by anaesthetic nurses. Acute cases include road trauma (over 3600 deaths on the road annually in a country where relatively few people actually have cars), injury by wild animals such as elephants, stabbings, acute abdomen and GI bleeding. Many cases that present are advanced and unlike anything you witness in western practise.

The older hospital has first year Bachelor of Medicine and Bachelor of Surgery trained doctors, called interns, who are expected to rotate through the various hospital departments like Australasian House Surgeons. The new hospital is just starting an Assistant Medial Officer school, which is to better equip those doctors with clinical training only.

In the two years Jenny has been in Arusha, she has had several medical visitors from Australasia. These are of great value to the hospital and assist with operations, teaching the interns and some providing a range of equipment. Visiting doctors certainly add value to a place with great need.

Should you wish to contact Jenny, she can be contacted through their website at www.africanpurpose.com

Changes to superannuation

Will you save enough for retirement? Tony Bongiorno says the reduced caps on super contributions will effect everyone

What will be the impact of the new changes to your Superannuation contributions, announced last May by the Federal Government?

Maybe more than you think, warns Tony Bongiorno, Founding Partner of Certified Practicing Accountants and business advisers, the Bongiorno Group, a firm that's been assisting medical professionals for more than 45 years.

Tony Bongiorno says the reduced caps on Super contributions will affect everyone's retirement savings - but the problems don't end there.

Tony outlines further potential drains on your capacity to save for the future with Michael Schildberger of Business Essentials. He starts with a reminder about the main changes to the rules?

Tony Bongiorno: The first and most obvious change is the reduced contribution cap. It means that surgeons of 50 years of age or more will only be able to contribute into superannuation and obtain a tax deduction for $50,000 a year. That has applied since July 2009 and for this age group, the contribution shrinks to $25,000 from 1 July 2012. We can't possibly see how surgeons will be able to save anywhere near enough for their retirement in this tax-effective environment with these small contributions caps.

Michael Schildberger: And Tony, that's not the only bad news?

Tony Bongiorno: In July 2006, Michael, the government of the day introduced more favourable rules relating to how much money you could accumulate in superannuation. The new pension rules were far less complicated than they had been previously, and it meant that even if you had several million dollars in superannuation, you could create a tax-free pension for your family in retirement once you reached age 60. And that all sounded very good.

Michael Schildberger: But that still applies?

Tony Bongiorno: Yes it does, but it meant that for most surgeons, the best place to own their life insurance and their total and permanent disability policies was either in their self-managed super fund, or under the superannuation fund environment provided by life companies and managed funds. So here's the problem. If you take a typical 40 year old surgeon with somewhere between 1.5 to two million dollars worth of life insurance cover, maybe more, plus total and permanent disability cover, their premium for that cover would be around about $2,500. That figure erodes the now $25,000 contribution to $22,500. And by the time they pay the 15 per cent tax on that, they're down to $19,000. That's hardly enough for a surgeon to retire on.

Michael Schildberger: Are you saying Tony, that surgeons should take their life cover out of the Super environment?

Tony Bongiorno: No, absolutely not. If the surgeon were to die or become disabled, it means he or she can create in most circumstances a tax free income stream for their family and at the same time obtain a tax deduction for the premium. So yes, the superannuation environment is the best place to house the insurance at the moment. But clearly the government hasn't thought through the dire consequences of the reduced savings. For example, if that surgeon was 48 years old, the premium for life and disability insurance would cost around $6,500. And that would reduce the $25,000 contribution down to $18,500. And then we'd take off the $15 per cent tax. So the older the surgeon gets, the higher the insurance premiums become, and the fewer amounts there is for retirement savings.

Michael Schildberger: Well, that's very serious. Do you believe that the Government contemplated this?

Tony Bongiorno: We are sure that the Government didn't contemplate this, and we're proposing a submission both to the Treasurer and to the Minister on this matter. Clearly, in our opinion, the contribution caps need to relate to savings for retirement and not include the cost of insurance perhaps up to a maximum amount. It's a very serious issue as surgeons get older because they still need their cover and they still need to save for retirement.

Michael Schildberger: You mentioned there's another problem.

Tony Bongiorno: Yes, and this has only surfaced recently. The problem applies to many surgeons, particularly those who may be salary sacrificing part of their hospital income into super. The reduced contribution cap applies from 1st July 2009 and for those surgeons who haven't gone back and addressed this situation, they could find that the amount that they're investing in superannuation, together with the amount that's designated for life insurance, could exceed the new contribution cap of $25,000 or $50,000.

Michael Schildberger: So what could that mean?

Tony Bongiorno: Put simply Michael, the tax penalty on the amount that they've over-contributed could amount to 46.5 per cent rather than 15 per cent.

Michael Schildberger: So you're saying that an unwitting over-contribution attracts 46.5 per cent tax?

Tony Bongiorno: Unfortunately yes, that's correct. And if the surgeon concerned also had unde ducted contributions in excess of the

allowable limit, say of $150,000, the tax could be as high as 93 per cent.

Michael Schildberger: And there's still one more problem?

Tony Bongiorno: Unfortunately, yes and this is one that we're not 100 per cent clear about because it's a very recent announcement. But most surgeons would have their life cover and their "own occupation" total and permanent disability cover owned in their super fund. In essence, the government has announced that, from 1 of July 2011, it will no longer accept this practice. And, by the way, it's never accepted the practice of owning critical illness insurance in superannuation funds. But it will now no longer accept "own occupation" total and permanent disability in the superannuation environment.

Michael Schildberger: So where should surgeons go from here? They obviously need to look closely at this.

Tony Bongiorno: Well, I think the first step is to confirm with their advisor the ownership of insurance. Who owns the policy, is it inside or outside super? Secondly, they should check

"The tax penalty on the amount that they've over-contributed could amount to 46.5 per cent rather than 15 per cent."

the amount that is intended to be claimed for those policies, to ensure that there is no over-contribution in this financial year. Incidentally, I've just seen a case where it would have been an excessive contribution, so they do need to check it pretty quickly. And thirdly, check that the additional amount of savings for retirement, added to the premium, does not exceed the cap if they're in the hospital environment.

Michael Schildberger: One final question. Presumably the same applies to contributions for spouses?

Tony Bongiorno: Yes, that's correct. But if a surgeon is paying their spouse a commercial salary, then on top of that salary the surgeon can make the maximum deductible contribution to superannuation for their spouse. The relevant taxation determination was in 2005, and it's on the Australian Tax Office (ATO) website. It's taxation determination 2005/24. Most surgeons would have been doing this from the 2004/2005 year, but it's just a reminder.

Michael Schildberger: So this will help surgeons to some extent?

Tony Bongiorno: It will help, but they must ensure that the salary is commercial and commensurate to the amount that would be paid to an arm's length person for services provided. Michael, I can absolutely guarantee to surgeons that the ATO will heavily police this issue over the next twelve months.

Michael Schildberger: In summary it looks as though you'll really be able to put less and less into super and get a tax deduction for that contribution?

Tony Bongiorno: Correct. So, in our next issue, we've got the Henry Report and other reports being published and hopefully we'll have a better idea of the government's directional thinking. And we can then expand on how self managed super fund borrowing can help surgeons acquire more shares or property.

Nine month old Liam (son of David Bartle, NZ) is Surgical News youngest fan.

Surgical News Index/Volume 10/2009

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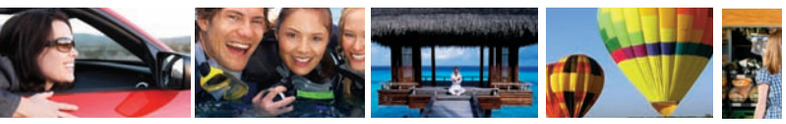

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The College finances and budget 2010

The Budget 2010 for the College was reviewed and approved at the October meeting of Council

Keith Mutimer,
Honorary Treasurer

In June 2009, the Council held a Budget Strategy meeting to review and approve the strategic initiatives for 2010. These initiatives formed the basis of the budget which determines the resource allocation to fund the activities of the College for the 2010 year.

Key attributes incorporated in the budget strategy review and the budget processes were to:

- Identify new key activities to commence in 2010 year in line with the Strategic Plan 2008 – 2015.
- Consider a College wide perspective to ensure all activities are included.
- Enable all key stakeholders to provide adequate input into the budget process.
- Achieve a budget surplus of nearly two per cent for College activities in accordance with the strategic plan.
- Ensure minimal cross subsidisation between areas of activity where ever possible and cross subsidies must be made apparent to Council.
- Undertake College Projects only if they fully cover all costs and only those deemed by Council to be strategically important will be allowed a "College contribution".
- Allocate, 50 per cent of surpluses (after all direct costs and College overheads) from completed College projects allocated to the Foundation for Surgery for ongoing commitment to international projects and surgical research.
- Increase subscriptions and all College fees by the CPI forecast of two per cent in 2010.
- Review of all New Zealand Dollars denominated fees to be charged at Australian dollars equivalent to consider parity in fee structure between the jurisdictions.
- Determine examination and training fees and ensure all related activities are self funding.
- Ensure all College infrastructure usage, including offices, is maximised for the benefit of all Trainees and Fellows.
- Trainee activities - aim is to ensure that all educational expenditure is fully funded from Trainee's fees.
- Fellow related activities - aim to ensure all expenditure is fully funded from annual subscriptions.

The Surgical Education and Training (SET) program was established in 2008 and it was agreed to undertake a review of the implementation of the program in 2010 to ensure the ongoing highest standards of quality and efficiency in surgical education and training.

The College operating activities continue to maintain a positive financial position and in 2010 will achieve a modest operating budget surplus of $514k (2009 – $706k). The surplus for 2010 is marginally below the College strategic plan target of a two per cent operational surplus but is expected to be achieved through active cost management of recurrent and capital expenditure. Also in accordance with College policy, this surplus excludes any returns from the investment reserve or Foundation for Surgery, some of which are distributed as research grants and scholarships, as Council continues its policy of not relying on investment returns to fund core operational activities.

The 2010 Budget continues the ongoing investment in Fellows' services and educational and research activities. It also supports the College structure and facilities that enables it to progress as the professional organisation responsible for surgical education and training in Australia and New Zealand.

College Activities in 2009

During the current year there has been considerable activity across the College operations including:

- Continued consolidation of the SET program post implementation in 2008.
- The College manages a diverse number of research, aid and audit projects with a total life contract value in excess of $49.9 million. Project activities are funded by external agencies and funding providers with a minimal funding contribution of $176k (2008 - $330k) from the College.
- Continued development and expansion of courses and workshops for surgical Trainees and Continuing Professional Development for Fellows.
- Ongoing development of relationships with the Specialist Surgical Societies and Associations regarding surgical training for the SET program and the operation of the Service Agreements into 2010.
- Ongoing administration of training in conjunction with Specialist Societies.
- Support for the Trainee Association in line with prior years.
- Ongoing review of the International Medical Graduates (IMGs) assessment process, with emphasis on support for IMGs in Area of Need positions.
- Support for the Basic Surgical Training program through to 2010.
- Ongoing development of the College website – www.surgeons.org with a revised format and improved functionality.
- Ongoing management of projects with the Commonwealth Government including Surgical Simulation Skills Program, Pacific Island Project – Phase III, Papua New Guinea Health Education and Clinical Services (HECS) program, The Australia Timor Leste Program of Assistance for Specialist Services (ATLASS), Surgical Morbidity and Mortality Audits and Australian Safety and Efficacy Register of New

Total 2010 College Budget including core operating, projects and investments

	Budget 2009 $000's	Budget 2010 $000's	Increase / (Decrease) %
Revenue*	43,834	40,791	(6.9%) ⬇
Expenditure*	42,663	39,532	7.3% ⬇
Operating Surplus	1,171	1,259	7.5% ⬆
Transfer to Foundation/ Investment Reserve (non operating activities)	1,011	1,251	23.7% ⬆
Total Surplus	2,182	2,510	15% ⬆

* - decrease due to reduced Category 2 activities

Interventional Procedures – Surgical (ASERNIP-S) related projects.

College Budget in 2010

The budget for 2010, reviewed and approved by Council, included the following key points:

- The parameters for the Budget Strategy approved at the June 2009 meeting of Council to be incorporated into budget 2010.
- The budget would generate a modest operating surplus of nearly two per cent for Category 1 activities in accordance with the strategic plan.
- Subscriptions to be increased by CPI of two per cent plus fee parity adjustment for New Zealand based Fellows. Australia based fellows - $2,100, New Zealand based Fellows $2,405 (2009 - $2,055) exclusive of Goods and Services Tax (GST) as disclosed on the College website.
- SET, course and examination fees will increase by CPI of two per cent plus fee parity adjustment for New Zealand based Trainees where applicable as disclosed on the College website.
- In recognition of fee parity in the College Fee Structure between Australian and New Zealand activities all fees and charges for New Zealand based Fellows and Trainees will be increased by 14.45 per cent (plus CPI of two per cent) being a 25 per cent discount of the average currency exchange rate for the past three years of 19.26 per cent as disclosed by the Reserve Bank of Australia.
- Cross subsidisation of activities will be minimised or made apparent.
- The subsidy for projects administered by the College will be $74k (2009 - $176k).
- All new projects will not receive a "College contribution" unless strategically important.
- College investments are budgeted for a 14% return (2009 - 10%) with an estimated return in 2009 of >20 per cent.
- The Treasurer's contingency has been decreased to $200k (2009 - $250k) to support funding of College New Key Initiatives.
- The Investment reserve retains all unallocated investment returns for future College initiatives including supporting the College Foundation for Surgery.

College Activities by category

The activities of the College are categorised as follows:

- Category 1 – College Operations and includes the operational and administrative services for the Educational, Governance and Resource activities of the College.
- Category 2 – College Projects and includes externally funded Research, Audit and Aid projects managed and administered by the College.
- Category 3 – Foundation and Investment Reserve and includes all activities relating to the Foundation for Surgery and the Investment Reserve.

Category 1 - In 2010 revenue for operational activities has increased by 2.9 per cent to $30,771k (2009 - $29,893k) while expenditure is budgeted to increase by 3.7 per cent to $30,257k (2009 - $29,187k). Overall this will result in a surplus for Category 1 activities of $514k (2009 - $706k).

Expenditure on category 1 activities will include:

- Staff Payroll and Oncosts – increase by 5.1 per cent to $11,648k (2009 - $11,079k) and includes an allowance for CPI increases of two per cent ($221k), net increase in new positions and salary reviews ($278k) and policy adoption of paid parental leave in 2009 ($50k).
- Consultants Fees – clinical - $501k (2009 - $413k) – activities for clinical/medical support and assessments, usually provided by Fellows of the College.
- Travel & Accommodation - $2,929k (2009 - $3,187k) – budgeted cost savings predominately in Australian domestic airfares.
- Property expenditure and maintenance - $1,142k (2009 - $1,043k) – related to temporary relocation of Queensland office and maintenance and restoration program for College properties in 2010.
- RACS scientific visitors program - $315k (2009 - $307k). This is a benefit for all Fellows with many scientific visitors also attending specialty society meetings.
- College Scholarships & Fellowships - $707k (2009 - $709k) – College funded scholarship program. This expenditure is in addition to scholarships funding of $903k (2009 - $793k) from bequest funds in category 3 for 2010. Overall scholarship →

funding (Cat 1 & Cat 3) totals $1,610k (2009 - $1,502k) or 7.4 per cent increase.

- A contribution for College projects of $74k (2009 - $176k) is included in expenditure for a number of projects administered by the College. This contribution represents the difference between the total indirect overheads incurred on the project and the amount which is allowed to be charged to the project in accordance with the contract. In 2010 the College contribution decreased by 42.1 per cent.

Category 2 - Revenue for College project activities in 2010 has decreased by 33.4 per cent to $8,395k (2009 - $12,603k) while expenditure is estimated to decrease by 33.6 per cent to $8,318k (2009 - $12,526k). Overall this will result in a modest surplus for Category 2 activities of $77k.

Expenditure on category 2 activities will include:

- Staff Payroll and oncosts - $1,912k (2009 - $2,973k) generally lower due to end of projects contracts.
- Consultants Fees - Clinical - $916k (2009 - $1,275k) – relates to professional services from external consultants for clinical / medical support and assessments provided to the College projects.
- Travel & Accommodation - $2,391k (2009 - $2,261k) – higher level of activity expected in planned number of trips for the ATLASS project.

Category 3 - Revenue for all activities relating to the Foundation for Surgery and the Investment Reserve has increased to $3,338k in 2010 (2009 - $2,683k). In 2010 the surplus will increase due predominately to increased investment returns to $1,918k surplus (2009 - $1,399k).

Balance Sheet

As at 31 December 2010, it is estimated that the College Net Assets will be $48,832k (2009 forecast - $46,323k). During the period, the Investment Reserve is budgeted to increase from $6,207k to $7,394k, generated from investment returns on funds not already committed to Research Scholarships and Grants or transferred to the Foundation for Surgery.

College Properties

The College owns properties in Adelaide, Brisbane, Melbourne and Sydney in Australia as well as Wellington in New Zealand. In Canberra, Hobart and Perth accommodation is leased for College offices

The investment in and maintenance of these properties continues to be significant cost in 2010 given the heritage nature of these properties. Overall expenditure for 2010 will be $1,142k (2009 - $1,043k) as well as allowing for capital expenditure on properties of $3,180k (2009 - $1,000k).

In 2009 and into 2010, the maintenance programs will continue to ensure that all properties are maintained on a continuing basis up to an acceptable standard.

During 2010 the College will be further developing its capital works and maintenance programs to ensure all key areas are planned and addressed. The review will cover all properties however initially the review of restoration and seismic strengthening works for the New Zealand property will be a key item of capital works for this program.

At its meeting in February 2008 Council approved the redevelopment on the Queensland property with a total overall project cost of $7.5 million (excl. GST). The Development Application for the Queensland Surgical Education and Communication Centre (QSEC) is progressing with timeline for construction to commence in late 2010 or 2011 dependant upon development application approval.

The West Wing redevelopment of the Melbourne property approved by Council in February 2008 has been completed in 2009 below the budget of $1,470k and ahead of schedule.

The College was bequeathed a property in the suburb of Paddington, Sydney by the late Mrs Elisabeth Unsworth which it intends to make available for sale in early 2010. The proceeds from the sale of the property will be added to the John Mitchell Crouch Research Fellowship fund for the ongoing awarding of research scholarships as was the wishes of Mrs Unsworth.

The ANZ debt related to the East Wing development of the Melbourne property has been fully repaid.

In Closing

As the year draws to a close it is evident that the College has achieved significant progress during 2009 in completing the key activities outlined in the Strategic Plan. The proposed initiatives, and challenges, for 2010, which I have outlined in my report, will ensure that the College continues to meet these challenges and progress in 2010.

I would like to thank my Deputy Treasurer, Mr Mike Hollands, for his continued support during 2009 and his oversight of property matters and especially the demands of the QSEC project in Queensland.

I would also like extend my warm thanks to the Honorary Advisers of the College, Mr Robert Milne, Mr Brian Randall, Mr Michael Randall, Mr Anthony Lewis and Mr Stuart Gooley for their ongoing advice and support. Also the advice, excellent service and support from Mr Graham Hope, Investment Adviser, of Goldman Sachs J B Were have continued to benefit the College enormously. The support provided by our Honorary Financial Advisers is exceptional and has been provided to us over many years

Also I would like to thank the Resources staff and the Director, Mr Ian T Burke, for their commitment, support and hard work in assisting me in my role as Honorary Treasurer.

Despite the pressure of these uncertain and demanding times on all of us, the financial position of the College continues on a solid base and is in excellent shape for the coming year.

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
SUMMARY OF SUBSCRIPTIONS, EDUCATION & TRAINING and OTHER FEES for 2010

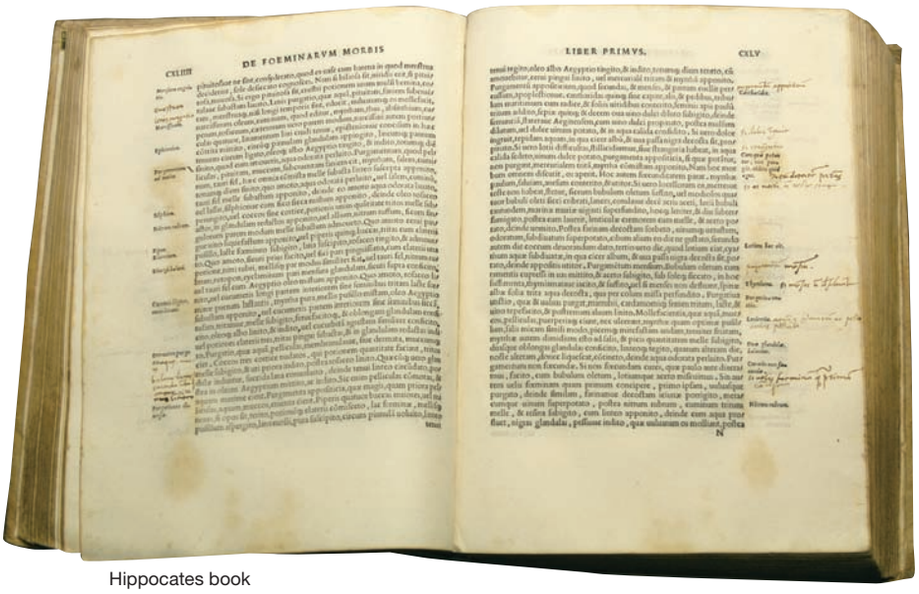
		2010 Fees AUS (Exc. GST)	2010 Fees AUS (Inc. GST)	2010 Fees NZ (Inc. GST)
SUBSCRIPTIONS & ENTRANCE FEES				
*	Annual Subscription - 2010 payable on 1 January 2010	$2,100.00	$2,310.00	$2,705.63
	Fellowship Entrance Fee payable in full (10% discount applies) or over 5 years - no CPI increase	$5,550.00	$6,105.00	$7,143.75
EDUCATION & TRAINING				
	Surgical Training			
	Administration Fee - exam pending and interruption (SET and BST)	$655.00	$720.50	$843.75
*	BST Annual Training Fee (Year 1,2,3 & 4)	$2,520.00	$2,520.00	$3,245.63
	Selection Processing Fee - (Note 6)	$560.00	$616.00	$720.00
	Selection Registration Fee	$370.00	$407.00	$478.13
*	SET Training Fee	$5,200.00	$5,200.00	$6,693.75
Examinations				
	Clinical Examination Fee	$1,700.00	$1,700.00	$2,188.13
	Fellowship Examination Fee	$6,180.00	$6,180.00	$7,959.38
	Generic Surgical Science Examination Fee	$2,975.00	$2,975.00	$3,830.63
	Orthopaedic Principles & Basic Science Examination Fee	$1,490.00	$1,490.00	$1,918.13
	Paediatric Anatomy and Embryology Examination Fee	$1,490.00	$1,490.00	$1,918.13
	Paediatric Pathophysiology Examination Fee	$745.00	$745.00	$956.25
	Plastic and Reconstructive Surgical Science & Principles Examination Fee	$1,490.00	$1,490.00	$1,918.13
	Speciality Surgical Science Examination Fee	$1,490.00	$1,490.00	$1,918.13
Skills Courses - refer to note 4				
	ASSET Course	$2,690.00	$2,959.00	$3,459.38
	CCrISP Course	$2,250.00	$2,475.00	$2,896.88
	CLEAR Course	$1,095.00	$1,204.50	$1,406.25
	STATS Course	$1,045.00	$1,149.50	$1,344.38
	EMST Course - Provider	$2,250.00	$2,475.00	$2,896.88
	EMST Course - Refresher	$1,435.00	$1,578.50	$1,850.63
PROFESSIONAL DEVELOPMENT WORKSHOPS & COURSES				
	Beating Burnout	$230.00	$253.00	N/A
	Mastering Difficult Clinical Interactions	$685.00	$753.50	$883.13
	From the Flight Deck	$895.00	$984.50	N/A
	Making Meetings More Effective	$460.00	$506.00	N/A
	Polishing Presentation Skills	$385.00	$423.50	N/A
	Practice Management for Practice Managers	$490.00	$539.00	N/A
	Surgical Teachers Course (STC)	$230.00	$253.00	N/A
	Writing Reports for Court	$765.00	$841.50	N/A
	Leadership in a Climate of Change	$1,800.00	$1,980.00	N/A
	Strategic Direction	$1,570.00	$1,727.00	N/A
	AMA Level 4/5: Difficult Cases	$75.00	$82.50	N/A
	Building Towards Retirement - Fellow	$195.00	$214.50	N/A
	Building Towards Retirement - Fellow & Partner	$290.00	$319.00	N/A
	Getting Px Back to Work	$70.00	$77.00	N/A
	Risk Management: Drafting a Consent	$180.00	$198.00	N/A
	Sustaining Your Business	$1,570.00	$1,727.00	N/A
	Understanding Your Px	$235.00	$258.50	N/A
	Working Together: Surgeons and Administrators	$185.00	$203.50	N/A
OTHER FEES				
	Appeals Lodgement Fee	$5,305.00	$5,835.50	N/A
	Distance Learning (Exam Preparation) Fee	$510.00	$561.00	N/A
	International Medical Graduates			
	Paper Based Assessment Fee	$4,245.00	$4,669.50	N/A
	Paper Based Assessment & Interview	$6,420.00	$7,062.00	N/A
	Supervision / Oversight Fee- onsite	$5,200.00	$5,720.00	N/A
	Supervision / Oversight Fee - remote	$14,850.00	$16,335.00	N/A
New	Document Assessment Fee - AoN subsequent to specialist assessment	$1,020.00	$1,122.00	N/A
New	Document Assessment Fee - College endorsement for AoN (Area of Need)	$1,020.00	$1,122.00	N/A
New	Assessment Fee - Reconsideration for Exceptional Performance	$2,040.00	$2,244.00	N/A
	Post Fellowship Education and Training			
New	Program Assessment Fee	$500.00	$550.00	$641.25
New	Annual Administration Fee	$100.00	$110.00	$129.38
	MOPS - Maintenance of Professional Standards			
	Australia & New Zealand	$1,680.00	$1,848.00	$2,160.00
	Occupational Training Visas	$815.00	$896.50	N/A

1. All fees are payable in either Australian or New Zealand Dollars as invoiced.
2. All New Zealand fees, including Examinations undertaken in New Zealand, are subject to the Goods & Services tax of 12.5%.
3. All Australian Fees will be subject to GST of 10% except approved Education courses.
4. Examination & training fees for Australian based activities have been approved by the Australian Taxation Office as GST free for all courses relating to the awarding of the RACS Fellowship.
5. Subscriptions and Fees marked within asterisk (*) may be paid to the College by 4 equal instalments during the year by AMEX, Visa or MasterCard credit cards only. Further details will be made available when fees are raised.
6. Fees may be charged for selection by General Surgery NZ, Paediatric, Otolaryngology AU and NZ, and Plastic Surgery NZ. Other specialty programs will publish their own selection processing fees

Hippocratis Coi editio princeps

The first Greek edition was published by Aldo Manuzzi in Venice, 1526

Keith Mutimer
Honorary Treasuer



Hippocates book

Among the many treasures of the Cowlishaw Collection is the first printed edition of the collected works of Hippocrates. The first printed edition of a work is traditionally known as the *editio princeps*, and the term is applied mostly to works of the ancient writers, which were for centuries copied by hand and circulated in manuscript form, before being printed for the first time in the 15th and 16th centuries.

Hippocrates needs little introduction. He was the principal medical authority in the West for almost 2000 years, from his own time up to the 16th century, when the works of anatomists like Andreas Vesalius undermined his influence. Hippocrates was born on the Greek island of Kos, in the Ægean Sea near Rhodes, c.460BC, and died, probably in Larissa, the capital of Thessaly, c.370BC, at the age of about 90 years.

Very little is known for certain about him, and a great deal of legend has grown up around him, so that now it is quite difficult to separate fact from fiction. The only authoritative account of his life was written by the eminent physician Soranos of Ephesos in the 1st/2nd century AD.

Soranos was active during the reigns of the emperors Trajan (98-117AD) and Hadrian (117-138AD), and practiced in Alexandria and then at Rome. He seems to have been an excellent clinician and a profuse writer. His best known surviving work is the treatise *Gynæcologia*. His life of Hippocrates was written long after the death of its subject, but it is the only account to survive from the ancient world, and given Soranos' reputation for thoroughness and objectivity, it is probably as reliable as could be expected.

Early in the 16th century an Italian scholar and translator, Marco Fabio Calvo of Ravenna (c.1440-1527), embarked on a project to make Hippocrates accessible to modern readers. Calvo was a friend of Raphael, and had already translated the works of the Roman architect Vitruvius into Italian for the great painter's personal use. Calvo had acquired a Greek manuscript of Hippocrates which he believed had been written in ancient times, but was in fact written in the 14th century.

He also consulted a 12th-century codex which is indeed one of the oldest and most important surviving texts of Hippocrates. From these he produced his own Greek manuscript which served as his exemplar, which he finished on 24 July 1512. This he translated into Latin, completing the task on 14 August 1515. It took another ten years for the Latin translation to appear in print. It was published by Francesco Minuzio Calvo, bookseller and "apostolic printer" to the papacy, in 1525, under the auspices of Pope Clement VII.

In 1526 Marco Calvo deposited his autograph copy of the Latin text in the papal library (*Vat. lat. 4416*), to serve as the archetype for future editions. He had intended to publish a Greek edition as well, but this did not come to fruition. He also gave his original Greek manuscript to the papal library (*Vat. gr. 227*). Both these manuscripts are still kept in the Vatican Library. The first Greek edition of Hippocrates was published by Aldo Manuzzi in Venice in 1526.

The *editio princeps* opens with an elaborate title page. The long title begins "Hippocratis Coi medicorum omnium longe principis, octaginta Volumina....." ("Eighty Volumes of Hippocrates of Kos, by far the first and foremost of all physicians....."). Then follows a page containing something like a copyright declaration, then two dedications to Pope Clement VII, then a table of contents, then the biographical account of Soranus, and finally the index listing all the topics covered in the book. This index is 66 pages in length. After that the text proper commences. The quality of the printing is exceptional, and this edition is generally regarded as one of the finest examples of book production of that era in Rome.

Leslie Cowlishaw acquired this copy from one of his regular suppliers, C.E. Rappaport,


HIPPOCRATIS
COI MEDICORVM OMNIVM
longe Principis, octoginta Volumina, quibus
maxima ex parte, annorum circiter duo mil
lia Latina caruit lingua, Graci uero, Arabes,
& Prisci nostri Medici, plurimis tamen utilibus
prætermissis, scripta sua illustrarunt, nunc
tandem per. M. Fabium Cãlium Rhauenna
tem uirum undecunq; doctissimum latinita-
te donata, CLEMENTI. VII. Pont. Max.
dicata, ac nunc primum in lucem ædita, quo
nihil humano generi salubrius fieri potuit.

Title page

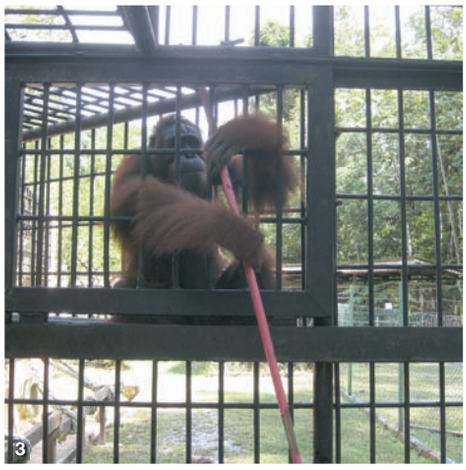
an antiquarian bookseller in Rome. Carl Ewald Rappaport founded the shop in 1906 after working for antiquarian booksellers in Germany, at about the same time as Cowlishaw started to become seriously interested in collecting. The shop still exists, run by his daughter and grandson, at 23 Via Sistina.

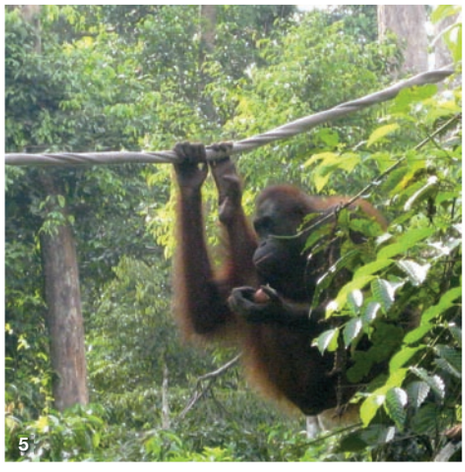
The College's copy is bound in old vellum, and although the sewing is becoming loose, is still in very good condition. There is some water staining on the pages at the back. At the foot of the title page is the name of a former owner in ink. The margins are copiously annotated in ink, and in many places passages of text are underlined. This indicates that this copy was once a working copy, read and used conscientiously.

This edition of Hippocrates is one of the most significant publications in the history of medical literature. Thanks to the astuteness of Leslie Cowlishaw, and the acumen of Sir Alan Newton, Kenneth Russell and others, it now enriches the College, and makes an important contribution to the medical heritage of Australia and New Zealand.

Geoff Down, College Curator







1. Lindy cleaning Aman's cage
2. Amam stealing Lindy's broom
3. Aman cleaning his cage
4. Destroying the broom
5. One of the Orang-utans who will be released shortly to live in the forest

Borneo orang-utan experience

Right now there are no more than 20,000 wildlife Orang-utans remaining and numbers are declining daily. The exploitation of tropical rainforest for timber coupled with large scale palm plantations and poaching for the black market have all contributed to the loss of these remarkable creatures.

I spent last month volunteering at the Matang Orang-utan rehabilitation centre in Sarawak Borneo. The centre was set up to house injured or orphaned Orang-utans caring for them and nursing them back to health before they can be released into the forest. Many that end up here have strayed into logging camps or been rescued from the illegal pet trade. Many are orphaned babies that can't survive in the forest alone.

This was a life changing experience working alongside trained experts and the indigenous people of Borneo watching these primates in their natural environment and living in captivity.

The daily work includes cleaning cages, maintenance and painting, teaching the babies to climb ropes and hiding food encouraging the young ones to forage for food sources.

For all those planning to holiday after the ASC 2012 in Kuala Lumpur consider staying on and volunteering in Sarawak (Matang) or Sabah (Sepillok) and experience something too amazing to put into words. Sepillok is also on the outskirts of Sandakan for those interested in learning more about the Mile 8 Camp, site of the infamous death marches in WW2 which saw only six Australian survivors from thousands of Prisoners of War.

For information on planning your trip contact Lindy Moffat on +61 3 9249 1224 or email lindy.moffat@surgeons.org

Lindy Moffat

Developing a Career in Academic Surgery

Monday 3 May 2010

(The day preceding the ASC)

Perth Convention and Exhibition Centre
7.00am – 4.00pm

The 2010 DCAS Course is set to intrigue and inspire participants with evolved themes and presenters, as well as several faculty returning from last year's successful inaugural course.

Designed for surgical trainees, research Fellows and early career academics, this inspirational course contains elements of interest for those from the stage of medical students to that of any surgeon who has ever considered involvement with publication or presentation of any academic work.

Key Note Speaker: Winthrop Professor Fiona Wood AM
"The highs and lows of a successful career in surgical research"

Topics addressed by an outstanding local and international faculty will include:

- Where do good ideas and research questions come from?
- How to design a study to get an answer
- What makes surgical research ethical? (and how to survive ethics applications!)
- Submitting and revising your work (including abstract writing)
- Private practice and research
- Finding the money for research
- How to integrate Clinical and Research interests into a rewarding academic program
- Why a trainee should consider doing full-time research
- Starting and planning a research career
- Why every surgeon could and should be an academic surgeon
- Creating and managing a clinical database
- How do you fit it in? - Work/life balance

But wait... there's more!

Two interactive workshop sessions with the experts, one to address individual career pathways, and the second to brainstorm challenges in any current research project. For the latter, registrants should bring their problems with them eg: the insoluble statistical dilemma, the unachievable ethics application, the project idea that won't come together.

The Association for Academic Surgery in partnership with the RACS Section of Academic Surgery

Proudly sponsored by Johnson & Johnson Medical

2009 Comments

"excellent talks"

"the sort of talk that every research Fellow needs to hear at the outset"

"challenging topics were covered extremely well"

Registration

Cost $150.00 inc. GST
Register on the ASC registration form or online at http://asc.surgeons.org.

Complimentary registration for interested medical students, contact dcas@surgeons.org for a separate registration form.

Further information

Conferences & Events Department,
Royal Australasian College of Surgeons

T: +61 3 9249 1273
F: +61 3 9276 7431
E: dcas@surgeons.org

NOTE: New RACS Fellows presenting for graduation in 2010 will be required to marshal at 3.30pm for the Convocation Ceremony.

Maximum 100 registrants, register early to avoid missing out.

The above themes/topic were correct at the time of printing however the Organising Committee reserve the right to change the themes/topics without notice. Email dcas@surgeons.org for updates.

The Course has been submitted to the RACS for approval within the CPD program. The CPD point allocation will be available at a later date.

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